Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2017

Pension Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	blic
Part I Anı	nual Report Idei	ntification Information				
For calendar plar	n year 2017 or fiscal	plan year beginning 01/01/2017	and ending 12/31/20	17		
A This return/re	port is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accord			
	2	x a single-employer plan	a DFE (specify)			
B This return/re	port is:	the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12	months))	
C If the plan is a	a collectively-bargain	ed plan, check here			• 🗌	
D Check box if f	filing under:	Form 5558	automatic extension	the	e DFVC program	
		special extension (enter description)				
Part II Bas	sic Plan Informa	ation—enter all requested informatio	n			
1a Name of plant HEALTH BENE		LOYEES OF UNIVERSITY HEALTH,	INC.	1b	Three-digit plan number (PN) ▶	501
				1c	Effective date of pla 01/01/1969	an
Mailing addr	ess (include room, a	if for a single-employer plan) pt., suite no. and street, or P.O. Box) puntry, and ZIP or foreign postal code	(if foreign, see instructions)	2b	Employer Identificati Number (EIN) 58-1581102	tion
UNIVERSITY HEALTH, INC.					2c Plan Sponsor's telephone number 706-722-9011	
1350 WALTON WAY AUGUSTA, GA 30901				2d Business code (see instructions) 622000		•

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	10/10/2018 Date	CHRISTOPHER WESTBROOK Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administra	tor's EIN
			3c Administra number	tor's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin	nce the last return/report filed for this plan,	4b EIN	
а	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name	m the last return/report:	4d PN	
С	Plan Name			
5	Total number of participants at the beginning of the plan year		5	4552
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d) .	d (welfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	4311
a(2) Total number of active participants at the end of the plan year		6a(2)	4474
b	Retired or separated participants receiving benefits		. 6b	241
С	Other retired or separated participants entitled to future benefits		6с	0
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d	4715
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	6e	
f	Total. Add lines 6d and 6e	. 6f		
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g	
h	Number of participants who terminated employment during the plan year with less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only			
	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H 4Q			
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all th	at apply)	
	(1) X Insurance (2) Code section 412(a)(3) insurance contracts	(1) X Insurance	ingurance centre	acto
	(2) Code section 412(e)(3) insurance contracts (3) Trust	(2) Code section 412(e)(3) (3) Trust	ilisurance contra	1015
	(4) X General assets of the sponsor	(4) X General assets of the s	ponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ttached, and, where indicated, enter the num	ber attached. (S	ee instructions)
а	Pension Schedules	b General Schedules		
-	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation)	
		(2) I (Financial Inform	mation – Small P	lan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3) X 6 A (Insurance Info	rmation)	
	actuary	(4) C (Service Provid	,	
	(2) SP (Single Employer Defined Penefit Dian Actuarie)	(5) D (DFE/Participat	,	tion)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6) G (Financial Tran	-	•

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Form 5500 (2017)	Page 3					
Part III Form M-1 Compliance Inform	nation (to be completed by welfare benefit ہ	plans)				
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
11b Is the plan currently in compliance with the Fo	orm M-1 filing requirements? (See instructions and 29 CFF	R 2520.101-2.) Yes No				
	2017 Form M-1 annual report. If the plan was not required to be filed under the Form Norm 5500 filing to rejection as incomplete.)					
Receipt Confirmation Code						

	EA	Insuranc	ce Information	า		014	ID No. 4040 0440
(Form 550	00)					IB No. 1210-0110	
Department of the Tre Internal Revenue Se	ervice	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).			2017		
Department of La Employee Benefits Security		File as an a	an attachment to Form 5500.				
Pension Benefit Guaranty	Corporation		are required to provide the information ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 2	017 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/3	31/2017	
A Name of plan HEALTH BENEFIT PLA	IN FOR EMPLO	YEES OF UNIVERSITY HEALTH	, INC.		e-digit number (PI	N) •	501
C Plan sponsor's name UNIVERSITY HEALTH,		e 2a of Form 5500			yer Identific 1581102	ation Number	(EIN)
		rning Insurance Contract . Individual contracts grouped as					
1 Coverage Information				·			
(a) Name of insurance of insura	EALTH, LLC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract		(f)	From	(g) To
0-0446713	60054	65155	4474		01/01/201	7	12/31/2017
	mmission informa	ation. Enter the total fees and tota	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
Insurance fee and co descending order of tl							and percente in
descending order of the		missions paid		(b) To	tal amount	of fees paid	and percent in
descending order of the	ne amount paid.	missions paid		(b) To	tal amount	of fees paid	unor portonio iii
descending order of the (a) Total	ne amount paid. I amount of com	missions paid ees. (Complete as many entries	as needed to report all	` ,	tal amount	of fees paid	
descending order of the (a) Total	ne amount paid. I amount of com			persons).		·	unor porcente iii
descending order of the (a) Total	ne amount paid. I amount of com	ees. (Complete as many entries		persons).		·	
descending order of the (a) Total	ne amount paid. I amount of communications I amount of communications and formula (a) Name a	ees. (Complete as many entries and address of the agent, broker,		persons). n commiss		·	
descending order of the (a) Total 3 Persons receiving co	me amount paid. I amount of community and formula (a) Name a	ees. (Complete as many entries and address of the agent, broker,	or other person to whor	persons). n commiss	ions or fees	·	(e) Organization code
descending order of the (a) Total 3 Persons receiving co (b) Amount of sales	me amount paid. I amount of community and formula (a) Name a	ees. (Complete as many entries and address of the agent, broker,	or other person to whor	persons). m commiss	ions or fees	·	
descending order of the (a) Total 3 Persons receiving co (b) Amount of sales	mmissions and for (a) Name a	ees. (Complete as many entries and address of the agent, broker,	or other person to whor	persons). m commiss ns paid (d) Purpose	ions or fees	were paid	

Fees and other commissions paid

(d) Purpose

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(c) Amount

(b) Amount of sales and base commissions paid

Schedule A (Form 5500) 2017 v. 170203

(e) Organization code

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 5 of 115 Page **2 -** 1 Schedule A (Form 5500) 2017 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e)

(b) Amount of sales and base

commissions paid

(c) Amount

(d) Purpose

Organization

code

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Schedule A (Form 5500) 2017

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F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts v	with each carrier may be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
		tracts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, che	ck here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	arate accounts)	
	а		ite participation	guarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(6)Total additions		7c(6)	
	Ч	Total of balance and additions (add lines 7b and 7c(6)).			(
		Deductions:		74	
	·	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account			
		(4) Other (specify below)	7e(4)		
		•			
				= - /=\	
		(5) Total deductions			

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A	(Form	5500	2017
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Page **4**

Р	art III	Welfare Benefit Contract Information on the contract covers the same to the contract covers the covers the contract covers the cov		e same em	yolqı	er(s) or members of	the same e	mplovee orga	nizations(s),
		the information may be combined for report	ng purposes if such cont	racts are e	xper	rience-rated as a uni	t. Where co	ontracts cover	individuaÌ
0	D ft .	employees, the entire group of such individe	uai contracts with each ca	arrier may i	be tre	eated as a unit for p	urposes or t	nis report.	
8	_	nd contract type (check all applicable boxes)	⊾ □ 5	_	. п.	\ r.		. ین □ له	
	=	ealth (other than dental or vision)	b Dental		범	Vision		d Life ins	
	e 📗 Te	emporary disability (accident and sickness)	f Long-term disabili	ty g	J ∐ :	Supplemental unem	ployment	h Prescri	otion drug
	i St	op loss (large deductible)	j HMO contract	k	(PPO contract		I Indemn	ity contract
	m X 01	ther (specify) FEMPLOYEE ASSISTANCE I	PROGRAM						
	ш								
9	Experience	ce-rated contracts:							
	a Prem	iums: (1) Amount received							
	(2) lı	ncrease (decrease) in amount due but unpaid		9a(2)					
	` '	ncrease (decrease) in unearned premium res					1		
		Earned ((1) + (2) - (3))					. 9a(4)		0
		efit charges (1) Claims paid							
		ncrease (decrease) in claim reserves					1		
	` '	ncurred claims (add (1) and (2))					9b(3)		0
	` '	Claims charged					. 9b(4)		
		nainder of premium: (1) Retention charges (o		0-(4)(A)				_	
		(A) Commissions		9c(1)(A)					
		(B) Administrative service or other fees		2 (4) (2)					
		(C) Other specific acquisition costs(D) Other expenses		0. (4) (D)	_				
		(E) Taxes		0.(4)(5)	_				
		(F) Charges for risks or other contingencies		0 (4)(5)	_				
		(G) Other retention charges		0. (4) (0)					
		(H) Total retention					9c(1)(H))	0
		` <i>`</i> Dividends or retroactive rate refunds. (These	_	_	_				
		us of policyholder reserves at end of year: (1	<u> </u>	<u> </u>					
		Claim reserves					9d(2)		
	` '	Other reserves					9d(3)		
	e Divi	dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c	(2) .).		. 9e		
10	Nonexp	erience-rated contracts:							
	a Tota	al premiums or subscription charges paid to c	arrier				. 10a		80792
	b If the	e carrier, service, or other organization incurr	ed any specific costs in c	onnection	with	the acquisition or			
	rete	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report a	mou	nt	10b		
	Specify r	nature of costs.							
Р	art IV	Provision of Information							
11		insurance company fail to provide any inform	ation necessary to comp	lete Schedi	ule A	Δ? Π	Yes	X No	
				ioto concui	alo F				
	12 If the answer to line 11 is "Yes," specify the information not provided.								

SCHEDULE A (Form 5500)

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

Department of Labor Employee Benefits Security Administration		Employee Retirement Income Security Act of 1974 (ERISA). File as an attachment to Form 5500.					2017	
Pension Benefit Guaranty Co	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					rm is Open to Public Inspection	
For calendar plan year 20°	17 or fiscal plaı	n year beginning 01/01/2017		and er	nding 12/3	31/2017		
A Name of plan	FOR EMPLOY	YEES OF UNIVERSITY HEALTH	LINC		e-digit		501	
TIENETTI BENETITI ENIV	TOTAL EMIT EO	reed of dividending the next	, 110.	plan	number (P	N) •	001	
				_				
C Plan sponsor's name a UNIVERSITY HEALTH, IN		e 2a of Form 5500			yer Identific 1581102	ation Number	(EIN)	
		rning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca			_					
(I-) FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
39-1263473	73288	736882	2522	2	01/01/201	7	12/31/2017	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	al commissions paid. L				other persons in	
(a) Total a	amount of com			(b) To	otal amount	of fees paid		
		40496					14969	
3 Persons receiving com		ees. (Complete as many entries				.,		
ACRISURE LLC DBA HEA			OF OTHER PERSON TO WHO WILLCREEK DRIVE STA, GA 30909	m commiss	sions or rees	were paid		
(b) Amount of sales ar	nd base	Fee	es and other commissio	ns paid				
commissions pai		(c) Amount	(d) Purpose				(e) Organization code	
	31899						3	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid		
ACRISURE LLC DBA ACH	IS INSURANC		RAIRIE CREEK SE DONIA, MI 49316					
(In) Among the Control		Fee	es and other commissio	ns paid				
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code	
	2901	14969 BC	ONUS				3	
For Paperwork Reductio	n Act Notice,	see the Instructions for Form 5	5500.			Sche	dule A (Form 5500) 2017	

v. 170203

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Page **2** – 1 Schedule A (Form 5500) 2017 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid THOMAS W. MAYER 55 5TH ST E STE 500 SAINT PAUL, MN 55101 Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code 5696 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code

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Schedule A (Form 5500) 2017

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I	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	with each carrier may	be treated	as a unit for purposes of
		this report.		,		
4		ent value of plan's interest under this contract in the general account at year			4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Cont	racts With Allocated Funds:				
	а	State the basis of premium rates •				
				-		
	b	Premiums paid to carrier		<u>-</u>	6b	
	С	Premiums due but unpaid at the end of the year		F	6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan chec	ck here		
7		racts With Unallocated Funds (Do not include portions of these contracts ma				
•	a		ite participation			
		(3) guaranteed investment (4) other				
	h	Delenes at the and of the provious year		Γ	7b	
	b C	Balance at the end of the previous year	7c(1)		7.0	
	C	(2) Dividends and credits	7c(1)			
		(3) Interest credited during the year	7c(3)			
			7c(4)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	/ C(3)			
		,				
		(6)Total additions		····· <u></u>	7c(6)	<u> </u>
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	0
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
)				
					7-/5	
		(5) Total deductions			7e(5)	C

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (I	Form 5500)	2017 (
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P	Welfare Benefit Contract Information If more than one contract covers the same group of employees the information may be combined for reporting purposes if such employees, the entire group of such individual contracts with ea	contracts are expe	erience-rated as a unit. Where c	ontracts cover individual
8	Benefit and contract type (check all applicable boxes)			
	a Health (other than dental or vision)	c X	Vision	d Life insurance
	e ☐ Temporary disability (accident and sickness) f ☐ Long-term dis	sability g	Supplemental unemployment	h Prescription drug
	i Stop loss (large deductible) j HMO contrac		PPO contract	I Indemnity contract
		·	T T O COMMUNICATION	
	m ☐ Other (specify) ▶			
9	Experience-rated contracts:			
Ū	a Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid			
	(3) Increase (decrease) in unearned premium reserve			
	(4) Earned ((1) + (2) - (3))		9a(4)	0
	b Benefit charges (1) Claims paid		, Jac.,	
	(2) Increase (decrease) in claim reserves			
	(3) Incurred claims (add (1) and (2))		9b(3)	0
	(4) Claims charged			
	C Remainder of premium: (1) Retention charges (on an accrual basis) -			
	(A) Commissions			
	(B) Administrative service or other fees			
	(C) Other specific acquisition costs	9c(1)(C)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies			
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention		9c(1)(H) 0
	(2) Dividends or retroactive rate refunds. (These amounts were page 2)	aid in cash, or	predited.) 9c(2)	
	d Status of policyholder reserves at end of year: (1) Amount held to pro	vide benefits after	retirement9d(1)	
	(2) Claim reserves		9d(2)	
	(3) Other reserves		9d(3)	
	e Dividends or retroactive rate refunds due. (Do not include amount en	tered in line 9c(2).) 9e	
10	Nonexperience-rated contracts:			
	a Total premiums or subscription charges paid to carrier		10a	350877
	b If the carrier, service, or other organization incurred any specific costs retention of the contract or policy, other than reported in Part I, line 2			
D	Part IV Provision of Information			
			10 N	V No
11		omplete Schedule	A? Yes	X No
12	If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	A	Insuran	ce Informatio	n		OM	IB No. 1210-0110	
(Form 5500)							IB NO. 1210-0110	
Department of the Treasu Internal Revenue Service		This schedule is required Employee Retirement In					2017	
Department of Labor Employee Benefits Security Adm	inistration	File as an	attachment to Form 55	00.				
Pension Benefit Guaranty Corp		Insurance companies	are required to provide t	he informat	tion	This For	This Form is Open to Public	
		<u>·</u>	ERISA section 103(a)(2)				Inspection	
For calendar plan year 201	/ or fiscal plai	n year beginning 01/01/2017		and en		31/2017	1	
A Name of plan HEALTH BENEFIT PLAN F	FOR EMPLO	YEES OF UNIVERSITY HEALTH	H, INC.		e-digit number (Pl	NI)	501	
				pian	number (i	<u>, , , , , , , , , , , , , , , , , , , </u>		
C Plan sponsor's name as	shown on lin	e 2a of Form 5500		D Emple	wer Identific	cation Number	(FINI)	
UNIVERSITY HEALTH, IN		e 2a 011 01111 3300		-	1581102	ation Number	(LIIV)	
		rning Insurance Contract L. Individual contracts grouped a						
1 Coverage Information:		<u> </u>			•			
(a) Name of insurance carr	ior							
IFE INSURANCE COMPA		'H AMERICA						
1100101102 0011171	TO HOR	TTTWENTON						
(b) FIN	(c) NAIC: (d) Contract or			ontract year				
(b) EIN (c) NATO code		identification number	persons covered a policy or contrac		(f)	From	(g) To	
3-1503749	65498	FLX 98014,3-4*	3625	5	01/01/201	7	12/31/2017	
2 Insurance fee and comm	nission informa	ation. Enter the total fees and tot	tal commissions paid. Li	ist in line 3	the agents.	brokers, and o	ther persons in	
descending order of the a			·			,	<u>'</u>	
(a) Total ar	mount of com	missions paid		(b) To	otal amount	of fees paid	00770	
		154350					20772	
3 Persons receiving comm		ees. (Complete as many entries						
		and address of the agent, broker,		m commiss	ions or fees	were paid		
OCKTON COMPANIES, LI	LC	2100 F SUITE	ROSS AVE. 1200					
			AS, TX 75201					
(b) Amount of sales and	l base	Fe	es and other commission	ns paid				
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code	
	154350	20772 S	UPPLEMENTAL COMM	IISSION			3	
	(a) Name a	and address of the agent, broker,	, or other person to who	m commiss	ions or fees	were paid		
	1						I	
(b) Amount of sales and	d base	Fe	es and other commission	ns paid			4	

(d) Purpose

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

(c) Amount

commissions paid

Schedule A (Form 5500) 2017 v. 170203

(e) Organization code

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 13 of 115 Page **2 -** 1 Schedule A (Form 5500) 2017 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code

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F	art	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	idual contracts	with each carrier may	be treated	d as a unit for purposes of
1	Curr	this report.	ond		4	
_		ent value of plan's interest under this contract in the general account at year			5	
-		ent value of plan's interest under this contract in separate accounts at year el tracts With Allocated Funds:	nu		3	
U		State the basis of premium rates				
	а	State the basis of premium rates *				
	b	Premiums paid to carrier		Г	6b	
	C	Premiums due but unpaid at the end of the year		l l	6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor		F		
	_	retention of the contract or policy, enter amount			6d	
		Specify nature of costs		_		
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	d annuity			
		(3) other (specify)				
		(b) The case (choosily)				
	f	If contract numbered in whole or in part to distribute benefits from a termin	ating plan abo	ak bara		
7		If contract purchased, in whole or in part, to distribute benefits from a termin				
1		tracts With Unallocated Funds (Do not include portions of these contracts ma		· ·		
	а		ite participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
				_		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	C
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	0
		(v) 10tal acadellolis			, 5(5)	

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

7f

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Part	Welfare Benefit Contract Informalif more than one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group of employees of th ting purposes if such con	tracts are ex	xper	rience-rated as a unit	. Where co	ontracts cover indi	
8 Ben	nefit and contract type (check all applicable boxes)			_			_	
а	Health (other than dental or vision)	b Dental	С		Vision		d X Life insurar	ice
е	Temporary disability (accident and sickness)	f X Long-term disabil	ity g	П	Supplemental unemp	oloyment	h Prescription	n drug
i İ	Stop loss (large deductible)	i HMO contract		_	PPO contract	•	I Indemnity of	-
m	X Other (specify) ►SUPP LIFE, DEP LIFE, ACC	• 🗆					- 🗀aəy	
m	Other (specify) FSOPP LIFE, DEP LIFE, ACC	JUENTAL DEATH AND	DISIMEMBE	KIVI	EINI			
9 Eyn	erience-rated contracts:							
	Premiums: (1) Amount received		9a(1)					
_	(2) Increase (decrease) in amount due but unpaid							
	(3) Increase (decrease) in unearned premium res		- '-				_	
	(4) Earned ((1) + (2) - (3))					9a(4)		0
b	Benefit charges (1) Claims paid					1(-/		
	(2) Increase (decrease) in claim reserves							
	(3) Incurred claims (add (1) and (2))					9b(3)		0
	(4) Claims charged					9b(4)		
С	Remainder of premium: (1) Retention charges (c	n an accrual basis)						
	(A) Commissions		9c(1)(A))				
	(B) Administrative service or other fees			_				
	(C) Other specific acquisition costs		9c(1)(C)	١				
	(D) Other expenses		-					
	(E) Taxes							
	(F) Charges for risks or other contingencies.			_				
	(G) Other retention charges					I		
	(H) Total retention			-		9c(1)(H))	0
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	cr	edited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1	,				9d(1)		
	(2) Claim reserves					9d(2)		
	(3) Other reserves					9d(3)		
<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2	(2) .).		. 9e		
_	onexperience-rated contracts:					- 40		
а	Total premiums or subscription charges paid to o	arrier				10a		2243525
b	If the carrier, service, or other organization incuring retention of the contract or policy, other than repectify nature of costs.					10b		
Part	IV Provision of Information		John Cohodu	ule A	м2 П	Yes	No	
	d the insurance company fail to provide any inform		lete Schedu	ule A	λ?	res	X No	
12 If t	the answer to line 11 is "Yes," specify the informat	ion not provided.						

SCHEDULE A Insurance Information (Form 5500)			ce Information	n		OMB No. 1210-0110	
Department of the Trea Internal Revenue Ser	asury	This schedule is required Employee Retirement In				2017	
Department of Lab Employee Benefits Security A		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty C	Corporation	Insurance companies a pursuant to E	are required to provide to ERISA section 103(a)(2)		ion	This Form is Open to Public Inspection	
For calendar plan year 20	017 or fiscal plan	year beginning 01/01/2017		and en	ding 12/31/	2017	
A Name of plan HEALTH BENEFIT PLAI	N FOR EMPLOY	EES OF UNIVERSITY HEALTH	I, INC.		e-digit number (PN)	<u> </u>	501
C Plan sponsor's name UNIVERSITY HEALTH,		e 2a of Form 5500			yer Identificat 1581102	ion Number	(EIN)
Part I Informa on a sepa	tion Concer rate Schedule A	ning Insurance Contract . Individual contracts grouped a	t Coverage, Fees, s a unit in Parts II and II	and Con I can be re	nmissions ported on a si	Provide info ngle Schedu	ormation for each contract ule A.
1 Coverage Information:							
a) Name of insurance can insurance can insurance can insurance can insurance can be a second or an insurance can be a second o						D. II	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	t end of	(f) F		(g) To
6-2739571	79413	0	224	ļ.	01/01/2017		12/31/2017
		ation. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents, br	okers, and	other persons in
	e amount paid.						
descending order of the	amount of comr	missions paid		(b) To	tal amount of	fees paid	
descending order of the		nissions paid		(b) To	tal amount of	fees paid	
descending order of th	amount of comr	missions paid ees. (Complete as many entries	as needed to report all		otal amount of	fees paid	
descending order of th	amount of comm			persons).			
descending order of th	amount of comm	ees. (Complete as many entries		persons).			
descending order of th (a) Total 3 Persons receiving con (b) Amount of sales a	amount of communications and feature (a) Name a	ees. (Complete as many entries nd address of the agent, broker,		persons). m commiss			
descending order of th (a) Total 3 Persons receiving con	amount of communications and feature (a) Name a	ees. (Complete as many entries nd address of the agent, broker,	or other person to who	persons). m commiss	ions or fees w		(e) Organization code

Schedule A (Form 5500) 2017 v. 170203

(c) Amount

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

(b) Amount of sales and base commissions paid

Fees and other commissions paid

(d) Purpose

(e) Organization code

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 17 of 115 Page **2 -** 1 Schedule A (Form 5500) 2017 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code

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F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	idual contracts with	each carrier may be treated as a ι	unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
-		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check h	ere 🕨	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation gua	rantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)	, , ,		
				- 10	
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
)			
		(5) Total deductions		7e(5)	C

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

7f

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Part III Welfare Benefit Contract Information If more than one contract covers the same group of employee the information may be combined for reporting purposes if sure employees, the entire group of such individual contracts with	ch contracts are expe	rience-rated as a unit. Where co	ntracts cover individual
8 Benefit and contract type (check all applicable boxes)	_		
a ⊠ Health (other than dental or vision) b ☐ Dental	c	Vision	d Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term	disability g	Supplemental unemployment	h Prescription drug
i Stop loss (large deductible) j HMO contra	act k	PPO contract	I Indemnity contract
m ☐ Other (specify)	Ц		
III Culci (Specify)			
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid			
(3) Increase (decrease) in unearned premium reserve	- ;-:		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid			
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis	s)		
(A) Commissions			
(B) Administrative service or other fees			
(C) Other specific acquisition costs			
(D) Other expenses			
(E) Taxes			
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges			
(H) Total retention	_		0
(2) Dividends or retroactive rate refunds. (These amounts were			
d Status of policyholder reserves at end of year: (1) Amount held to p			
(2) Claim reserves			
(3) Other reserves			
e Dividends or retroactive rate refunds due. (Do not include amount	entered in line 9c(2).)	9e	
10 Nonexperience-rated contracts:		10	
Total premiums or subscription charges paid to carrier			330467
b If the carrier, service, or other organization incurred any specific co retention of the contract or policy, other than reported in Part I, line Specify nature of costs.			
Part IV Provision of Information			
	o completo Schodula i	A? Yes	X No
11 Did the insurance company fail to provide any information necessary to		4:	N 140
12 If the answer to line 11 is "Yes," specify the information not provided.	,		

001150111							
SCHEDUL		Insuran	ce Informatio	n		OM	IB No. 1210-0110
(Form 55 Department of the T Internal Revenue S	reasury	This schedule is required Employee Retirement In					2017
Department of L	abor	• •	attachment to Form 55	•)-		2017
Employee Benefits Security Pension Benefit Guarante	<u> </u>				tion		
	, ,	▶ Insurance companies a pursuant to I	ERISA section 103(a)(2)		liOH	This For	m is Open to Public Inspection
For calendar plan year	2017 or fiscal pla	an year beginning 01/01/2017		and er	iding 12/3	31/2017	
A Name of plan HEALTH BENEFIT PL	AN FOR EMPLO	YEES OF UNIVERSITY HEALTH	H, INC.		e-digit number (P	N) •	501
C Plan sponsor's nam	ne as shown on lir	 ne 2a of Form 5500		D Emple	ver Identific	cation Number ((FINI)
UNIVERSITY HEALTH		ie za di Folili 3300		-	1581102	auon Number ((LIIV)
		rning Insurance Contract A. Individual contracts grouped a					
1 Coverage Information	on:						
(a) Name of insurance		DMPANY					
(b) [IN]	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of			Policy or co	ontract year
(b) EIN (code		identification number	policy or contrac		(f)	From	(g) To
6-0307623	85766	89947	2926	6	01/01/201	7	12/31/2017
2 Insurance fee and condescending order of		nation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Tot	tal amount of com	ımissions paid		(b) To	otal amount	of fees paid	
		113321					0
3 Persons receiving c	ommissions and	fees. (Complete as many entries	as needed to report all	persons).			
		and address of the agent, broker,		m commiss	ions or fees	were paid	
CRISURE INSURANC	Æ		HILLCREEK DRIVE STA, GA 30909				
(b) Amount of sales	s and base	Fed	es and other commission	ns paid			-
commissions		(c) Amount		(d) Purpos	е		(e) Organization code
	113321						3
	(a) Name	and address of the agent, broker,	, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales	s and base		es and other commission	•			_
commissions	naid	(c) Amount		(d) Durnos	Δ		(a) Organization code

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	idual contracts with	each carrier may be treated as a ι	unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
-		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check h	ere 🕨	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation gua	rantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)	, , ,		
				- 10	
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
)			
		(5) Total deductions		7e(5)	C

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (Form 5500) 2017

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P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.								
8	Benefit	and contract type (check all applicable boxes)	_	_	_		_		
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance		
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	loyment	h Prescription drug		
	_ =	Stop loss (large deductible)	j HMO contract		PPO contract	•	I Indemnity contract		
		Other (specify)	• 🗆	L	<u> </u>		□ ,		
	⊔	Other (specify)							
9	Evnerie	ence-rated contracts:							
J		emiums: (1) Amount received		9a(1)		2312897	,		
) Increase (decrease) in amount due but unpaid				2012001			
) Increase (decrease) in unearned premium res							
) Earned ((1) + (2) - (3))				9a(4)	2312897		
	. `	enefit charges (1) Claims paid				1792941			
) Increase (decrease) in claim reserves		:-:		23352			
	•) Incurred claims (add (1) and (2))				9b(3)	1816293		
) Claims charged				9b(4)			
	` `	emainder of premium: (1) Retention charges (o		•••••		0.0(1)			
	•	(A) Commissions		9c(1)(A)		113321			
		(B) Administrative service or other fees		9c(1)(B)		304850			
		(C) Other specific acquisition costs		0 (4)(0)		001000			
		(D) Other expenses		0 (4)(D)					
		(E) Taxes		0 (4)(5)		75169			
		(F) Charges for risks or other contingencies				23129			
		(G) Other retention charges		- (1)(-)		20120			
		(H) Total retention				9c(1)(H)	516469		
	(2	Dividends or retroactive rate refunds. (These	_	_			313133		
	-		ш .		•	9c(2)			
		tatus of policyholder reserves at end of year: (1	•			9d(1)	4.45202		
	•) Claim reserves				9d(2)	145303		
	`) Other reserves				9d(3)			
40		ividends or retroactive rate refunds due. (Do no	ot include amount entered	a in line 9c(2)	.)	9e			
10		xperience-rated contracts:	•		ĺ	40-			
	_	otal premiums or subscription charges paid to c				10a	_		
		the carrier, service, or other organization incurr				40h			
	re Specifi	tention of the contract or policy, other than report of nature of costs.	orted in Part I, line 2 abov	e, report amo	ount	10b			
P	art IV	Provision of Information					_		
			otion non	loto Cala alici	. Д	Ves	X No		
11		ne insurance company fail to provide any inform		iete Schedule	A?	Yes	NU INU		
12	! If the	12 If the answer to line 11 is "Yes," specify the information not provided.							

SCHEDULE A (Form 5500)

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

Internal Revenue Ser		Employee Retirement Inc	Employee Retirement Income Security Act of 1974 (ERISA).				2017
Department of Labo Employee Benefits Security Ad		File as an attachment to Form 5500.					
Pension Benefit Guaranty C	orporation	Insurance companies ar pursuant to Ef	re required to provide t RISA section 103(a)(2)		tion	This Fo	orm is Open to Public Inspection
For calendar plan year 20)17 or fiscal plar	n year beginning 01/01/2017		and er	nding <u>12/3</u>	31/2017	
A Name of plan HEALTH BENEFIT PLAN	N FOR EMPLOY	YEES OF UNIVERSITY HEALTH,	INC.		e-digit number (Pl	N) •	501
C Plan sponsor's name a UNIVERSITY HEALTH, I		e 2a of Form 5500			oyer Identific -1581102	ation Numbe	r (EIN)
Part I Informa on a separ	tion Concer rate Schedule A	rning Insurance Contract . Individual contracts grouped as	Coverage, Fees, a unit in Parts II and I	and Cor	nmission ported on a	S Provide inf single Sched	ormation for each contract ule A.
1 Coverage Information:							
(a) Name of insurance ca		NY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				contract year
(b) Liiv	code	identification number	policy or contract		(f)	From	(g) To
41-0451140	67105	690511	1857	7	01/01/201	7	12/31/2017
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees paid	
		225787					37240
3 Persons receiving com	nmissions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
		and address of the agent, broker, o			sions or fees	were paid	
ACRISURE LLC			RAIRE CREED DRIVE ONIA, MI 49316	SE			
(b) Amount of sales a	nd hase	Fees	s and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	191182						3
	(a) Name a	and address of the agent, broker, o	or other person to who	m commiss	sions or fees	were paid	
HODGES - MACE BENEF	FITS GROUP IN		GLENRIDGE DRIVE, FA, GA 30328	SUITE 350			
(h) Amount of column	nd boos	Fees	s and other commissio	ns paid			
(b) Amount of sales a commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	26417	34892 SE	RVICE FEE				3
For Paperwork Reduction	on Act Notice,	see the Instructions for Form 55	500.			Sch	edule A (Form 5500) 2017

v. 170203

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 25 of 115 Page **2 -** 1 Schedule A (Form 5500) 2017 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid BENEFIT ADVISORS SERVICE GROUP LLC 1120 SANCTUARY PKWY SUITE 300 ALPHARETTA, GA 30097 Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount (d) Purpose commissions paid code 8188 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 2965 US-19 ALT PALM HARBOR, FL 34683 **ACRISURE LLC** Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 2348 SUPPLEMENTAL COMMISSION 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code

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Schedule A (Form 5500) 2017

Page 3

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts v	with each carrier may be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
		ent value of plan's interest under this contract in separate accounts at year e			
		tracts With Allocated Funds:		•	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, che	ck here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	arate accounts)	
	а		ite participation	guarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	. 7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(6)Total additions		7c(6)	
	Ч	Total of balance and additions (add lines 7b and 7c(6)).			(
		Deductions:		74	
	·	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account			
		(4) Other (specify below)	7e(4)		
		•			
				= - /=\	
		(5) Total deductions			

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (Form 5500) 2017
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Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such comployees, the entire group of such individual contracts with each	ntracts are experience-rated	as a unit. Where contracts cover	
8 Benefit and contract type (check all applicable boxes)	_	<u></u>	
a ☐ Health (other than dental or vision) b ☐ Dental	C Vision	d Life ins	urance
e ▼ Temporary disability (accident and sickness) f Long-term disab	oility g Supplemen	tal unemployment h \square Prescr	ption drug
i ☐ Stop loss (large deductible) i ☐ HMO contract	k ☐ PPO contra	- 片	nity contract
	K 11 0 contra		nty contract
m ✓ Other (specify) ►ACCIDENT, CRITICAL ILLNESS			
O Francisco control controls			
9 Experience-rated contracts:	90(1)		
a Premiums: (1) Amount received			
(2) Increase (decrease) in amount due but unpaid	2 (2)		
(3) Increase (decrease) in unearned premium reserve		9a(4)	0
b Benefit charges (1) Claims paid		3a(4)	
(2) Increase (decrease) in claim reserves			
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged(4)		9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)		35(4)	
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees			
. ,	0-(4)(0)		
(C) Other specific acquisition costs(D) Other expenses	0 (4)(D)		
	0.(4)(5)		
(E) Charges for risks or other contingencies	0 (4)(5)		
(F) Charges for risks or other contingencies	2 (1)(2)		
(G) Other retention charges		9a(4)(H)	0
(H) Total retention	_	` /` /	
(2) Dividends or retroactive rate refunds. (These amounts were paid	<u> </u>		
d Status of policyholder reserves at end of year: (1) Amount held to provide		` ` `	
(2) Claim reserves		- · · ·	
(3) Other reserves		- '	
Dividends or retroactive rate refunds due. (Do not include amount enter	red in line 9c(2) .)	9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier		10a	1274543
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 ab Specify nature of costs.			
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to com	nplete Schedule A?	Yes X No	
12 If the answer to line 11 is "Yes," specify the information not provided.			

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> > Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2018

Pension Benefit Guaranty Corporation			Inis Form is Open to Public Inspection			
Part I Annual Report	dentification Information					
For calendar plan year 2018 or fis	scal plan year beginning 01/01/2018	and ending 12/31/20	018			
A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions						
B This return/report is:	the first return/report	the final return/report				
	X an amended return/report	a short plan year return/report (less than 12	2 months)			
C If the plan is a collectively-bar	gained plan, check here					
D Check box if filing under:	X Form 5558	automatic extension	X the DFVC program			
	special extension (enter description	on)				
Part II Basic Plan Info	rmation—enter all requested information	tion				
1a Name of plan HEALTH BENEFIT PLAN FOR B	EMPLOYEES OF UNIVERSITY HEALT	H, INC.	1b Three-digit plan number (PN) ▶ 501			
	1c Effective date of plan 01/01/1969					
2a Plan sponsor's name (emplo Mailing address (include roor City or town, state or provinc	2b Employer Identification Number (EIN) 58-1581102					
UNIVERSITY HEALTH, INC.	2c Plan Sponsor's telephone number 706-722-9011					
1350 WALTON WAY AUGUSTA, GA 30901			2d Business code (see instructions) 622000			

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	10/25/2019 Date	DAVID BELKOSKI Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2018) v. 171027

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	Form 5500 (2018)	Pa	age 2			
3a	Plan administrator's name and address X Same as Plan Sponsor				3b Adr	ministrator's EIN
		3c Administrator's telephone number				
4	If the name and/or EIN of the plan sponsor or the plan name has changed sine enter the plan sponsor's name, EIN, the plan name and the plan number from				4b EIN	I
	Sponsor's name Plan Name				4d PN	
5	Total number of participants at the beginning of the plan year				5	4678
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	ל (welfare plan	ns com	plete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year				6a(1)	4466
a(2	2) Total number of active participants at the end of the plan year				6a(2)	4469
b	Retired or separated participants receiving benefits				6b	189
С	Other retired or separated participants entitled to future benefits				. 6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c				. 6d	4658
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits.			. 6e	
f	Total. Add lines 6d and 6e				. 6f	
g	Number of participants with account balances as of the end of the plan year (complete this item)				. 6g	
	Number of participants who terminated employment during the plan year with less than 100% vested				6h	
7	Enter the total number of employers obligated to contribute to the plan (only		•		7	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H 4Q	les from the Li	ist of Pl	an Characteristics Code	s in the in	
9a	Plan funding arrangement (check all that apply) (1) X Insurance	(1)	enefit a <mark>√</mark>	rrangement (check all that Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Ĥ	Code section 412(e)(3)	insurance	e contracts
	(3) Trust	(3)		Trust		
40	(4) X General assets of the sponsor	(4)	X	General assets of the sp		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and, v	where	indicated, enter the numb	oer attach	ned. (See instructions)
а	Pension Schedules	b Gener	al Sch			
	(1) R (Retirement Plan Information)	(1)		H (Financial Inforr	•	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)		I (Financial Inform		Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X	6 A (Insurance Infor	,	
	actuary	(4)	닏	C (Service Provide		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	닏	D (DFE/Participati	•	•
	Information) - signed by the plan actuary	(6)	Ц	G (Financial Trans	saction S	chedules)

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 30 of 115

SCHEDULE A **Insurance Information** OMB No. 1210-0110 (Form 5500) This schedule is required to be filed under section 104 of the Department of the Treasury Internal Revenue Service 2018 Employee Retirement Income Security Act of 1974 (ERISA). Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500. Pension Benefit Guaranty Corporation Insurance companies are required to provide the information This Form is Open to Public pursuant to ERISA section 103(a)(2). Inspection 12/31/2018 For calendar plan year 2018 or fiscal plan year beginning and ending 01/01/2018 A Name of plan В Three-digit HEALTH BENEFIT PLAN FOR EMPLOYEES OF UNIVERSITY HEALTH, INC. 501 plan number (PN) C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) UNIVERSITY HEALTH, INC. 58-1581102 Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract Part I on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier AETNA BEHAVORIAL HEALTH, LLC (e) Approximate number of Policy or contract year (c) NAIC (d) Contract or (b) EIN persons covered at end of code identification number **(g)** To (f) From policy or contract year 20-0446713 60054 01/01/2018 4403 12/31/2018 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (b) Amount of sales and base (d) Purpose (e) Organization code commissions paid (c) Amount (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid

(c) Amount

(d) Purpose

(e) Organization code

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule A (Form 5500) 2018 v. 171027

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Schedule A (Form 5500)	2018	Page 2 – 1					
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid					
(4)		,					
Fees and other commissions paid (c							
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(a) Nai	ne and address of the agent, broke	r, or other person to whom commissions or rees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
•							
(a) No.	no and address of the agent broke	r or other person to whom commissions or fees were paid					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) No.	no and address of the agent broke	r, or other person to whom commissions or fees were paid					
(a) Nai	ne and address of the agent, broke	r, or other person to whom commissions or rees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
·							
(a) No.	no and address of the agent brake	r or other nersen to whom commissions or feet were noid					
(a) Nai	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e) Organization				
(b) Amount of sales and base commissions paid	(c) Amount) Amount (d) Purpose					
1			code				
		I.	1				

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Schedule A (Form 5500) 2018

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Part II Investment and Annuity Contract Information									
			al contracts are provided, the	e entire group of such indiv	idual contra	icts with each car	rier may be trea	ated as a unit f	or purposes of
4	Cur	this report.	erest under this contract in the	ne general account at year	end		4		
5			erest under this contract in s						
6		tracts With Allocated F		oparate accounts at your c	, iid				
Ŭ	a	State the basis of pre							
	_	orate the gaete et pro	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	b	Premiums paid to ca	rrier				6b		
	С	•	npaid at the end of the year.						
	d		, or other organization incurr						
			act or policy, enter amount.						
		Specify nature of cos	its 🕨						
	е	Type of contract: (1) individual policies	(2) group deferre	ed annuity				
		(3) other (specify	/) ▶						
	f	If contract purchased	I, in whole or in part, to distri	bute benefits from a termi	nating plan	check here	▶ □		
7			d Funds (Do not include por				te)		
•	a	Type of contract:	(1) deposit administrati			ition guarantee	13)		
	u	Type of contract.	`' '	· · · 📙		aton guarantee			
			(3) guaranteed investm	ent (4) other					
								<u> </u>	
	b		f the previous year				7b		
	С	` '	butions deposited during the	•	- ;-;				
		` '	edits		- (2)				
		` '	during the year						
		` '	separate account						
		(5) Other (specify be	low)		7c(5)				
		•							
		(6)Total additions						5)	
	d	Total of balance and a	additions (add lines 7b and 7	'c(6))	г		7d		C
	е	Deductions:			- 4				
			nd to pay benefits or purcha		7e(1)				
			arge made by carrier		- (-)				
			parate account						
		(4) Other (specify bel	ow)		7e(4)				
		•							
		(F) T-t-1 -ll					70/5	3	

Balance at the end of the current year (subtract line 7e(5) from line 7d)

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Schedule A (Form 5500) 2018

Page 4

Pa	If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such cont employees, the entire group of such individual contracts with each care.	racts are exp	perience-rated as a unit. Where contracts	cover individual
8 E	Benefit and contract type (check all applicable boxes)			
	a ☐ Health (other than dental or vision) b ☐ Dental	сГ	Vision d L	ife insurance
		<u></u>	ᅼ	
(e		- · · · · · · · · · · · · · · · · · · ·	rescription drug
İ	i Stop loss (large deductible) j HMO contract	k _	PPO contract	ndemnity contract
ı	m X Other (specify) ▶EMPLOYEE ASSISTANCE PROGRAM			
9 E	Experience-rated contracts:			
á	a Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve			
	(4) Earned ((1) + (2) - (3))		9a(4)	0
	b Benefit charges (1) Claims paid			
	(2) Increase (decrease) in claim reserves			
	(3) Incurred claims (add (1) and (2))			0
	(4) Claims charged		9b(4)	
	c Remainder of premium: (1) Retention charges (on an accrual basis)	a (4)(a)		
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees	9c(1)(B)		
	(C) Other specific acquisition costs	9c(1)(C) 9c(1)(D)		
	(D) Other expenses	0-(4)(5)		
	(E) Charges for risks are they continuousles			
	(F) Charges for risks or other contingencies	9c(1)(G)		
	(G) Other retention charges(H) Total retention		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were paid in		- ' ' 	
	d Status of policyholder reserves at end of year: (1) Amount held to provide		- · · · · · · · · · · · · · · · · · · ·	
	(2) Claim reserves			
	(3) Other reserves		· · · · · ·	
	e Dividends or retroactive rate refunds due. (Do not include amount entered Nonexperience-rated contracts:	111 IIIIe 3C(2)	J.) 3e	
	Total premiums or subscription charges paid to carrier		10a	67856
				07030
	b If the carrier, service, or other organization incurred any specific costs in c retention of the contract or policy, other than reported in Part I, line 2 abov Specify nature of costs.			
	art IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to compl	lete Schedule	e A? Yes X No	
12	If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A
(Form 5500)
Department of the Treasury Internal Revenue Service
Department of Labor bloyee Benefits Security Administr
ension Benefit Guaranty Corporat

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

Internal Revenue Serv	ice	Employee Retirement Inc	come Security Act of 19	974 (ERISA	.).		2018
Department of Labor Employee Benefits Security Ad	rtment of Labor						
Pension Benefit Guaranty Co	prporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	rm is Open to Public Inspection	
For calendar plan year 20	18 or fiscal plar	n year beginning 01/01/2018		and en	nding 12/3	1/2018	
A Name of plan HEALTH BENEFIT PLAN FOR EMPLOYEES OF UNIVERSITY HEALTH			INC.		e-digit number (Pl	N) •	501
C Plan sponsor's name a UNIVERSITY HEALTH, IN		e 2a of Form 5500			oyer Identific 1581102	ation Number	(EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:		9·					·-···
(a) Name of insurance ca							
HOWANA INSURANCE CO	JIVIPANT	T			T	Dallarrana	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate no persons covered a	t end of	(f)	From	ontract year (g) To
39-1263473	73288	736882	policy or contract	•	01/01/201		12/31/2018
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
(a) Total a	amount of comr	missions paid		(b) To	otal amount	of fees paid	
		69219					11591
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
		nd address of the agent, broker, o		m commiss	ions or fees	were paid	
ACRISURE LLC DBA HEA	AD CAPITAL		LLCREEK DRIVE TA, GA 30909				
(b) Amount of sales ar	nd base	Fees	s and other commissio	ns paid			_
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	39096						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
THOMAS W. MAYER	. , ,	55 5TH	ST E STE 500			'	
		SAINTE	PAUL, MN 55101				
(b) Amount of sales ar	nd base	Fees	s and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
	30099						3
For Paperwork Reduction	n Act Notice,	see the Instructions for Form 5	500.			Sche	dule A (Form 5500) 2018

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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid CRISURE LLC DBA ACHS INSURANCE 1201 TOWN PARK LANE EVANS, GA 30809 Fees and other commissions paid (b) Amount of sales and base	(e) Organization code 3						
CRISURE LLC DBA ACHS INSURANCE 1201 TOWN PARK LANE EVANS, GA 30809 Fees and other commissions paid (b) Amount of sales and base	Organization code						
(b) Amount of sales and base	Organization code						
(b) Amount of sales and base	Organization code						
commissions paid (c) Amount (d) Purpose	3						
24 11591 BONUS							
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
Fees and other commissions paid	(e) Organization						
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose	code						
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales and base Fees and other commissions paid	(e) Organization						
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(b) Amount of sales and base	(e) Organization						
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commissions paid (c) Amount (d) Purpose	code						

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Schedule A (Form 5500) 2018

Page 3

F	Part	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indiv	idual contrac	cts with each carrier ma	y be treated a	s a unit for purposes of
1	Curr	this report.	and		4	
<u>4</u>		ent value of plan's interest under this contract in the general account at year			5	
6		ent value of plan's interest under this contract in separate accounts at year e tracts With Allocated Funds:	11 u		5	
U	a	State the basis of premium rates				
	u	otate the basis of premium rates **				
	b	Premiums paid to carrier			6b	
	c	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in co				
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan	heck here		
7		·	<u> </u>			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma		ion guarantee		
	а			ion guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	_ ` /			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	0
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account				
		(4) Other (specify below)	7e(4)			
		>				
					70(F)	

Balance at the end of the current year (subtract line 7e(5) from line 7d)

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Schedule A (Form 5500) 2018

									_
P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s),								
		the information may be combined for report							
		employees, the entire group of such individ	ual contracts with each ca	arrier may	be tr	reated as a unit for p	urposes of t	his report.	
8	Benefit a	nd contract type (check all applicable boxes)							
	а 🗌 н	ealth (other than dental or vision)	b Dental	C	X	Vision		d Life insurance	
	e \prod Te	emporary disability (accident and sickness)	f Long-term disability	ty Q	3 🗌	Supplemental unem	ployment	h Prescription drug	
	i St	op loss (large deductible)	j HMO contract	k	⟨☐	PPO contract		I Indemnity contract	
	$\mathbf{m} \square \circ$	ther (specify)	_					_	
	🗆 🗸	(5655)							
9	Experien	ce-rated contracts:							
	a Prem	iums: (1) Amount received		9a(1)					
	(2) I	ncrease (decrease) in amount due but unpaid	l						
	(3) I	ncrease (decrease) in unearned premium res	erve	9a(3)					
	(4) E	Earned ((1) + (2) - (3))					9a(4)		0
	b Ben	efit charges (1) Claims paid		9b(1)					
	(2) I	ncrease (decrease) in claim reserves		9b(2)					
	(3) I	ncurred claims (add (1) and (2))					9b(3)		0
	` '	Claims charged					9b(4)		
	C Ren	nainder of premium: (1) Retention charges (o	n an accrual basis)						
		(A) Commissions		9c(1)(A					
		(B) Administrative service or other fees			_				
		(C) Other specific acquisition costs		9c(1)(C	_				
		(D) Other expenses		9c(1)(D 9c(1)(E					
		(E) Taxes		0.74\/E					
		(F) Charges for risks or other contingencies		9c(1)(G					
		(G) Other retention charges (H) Total retention					9c(1)(H)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0
		Dividends or retroactive rate refunds. (These	_	-	_			1	Ť
		tus of policyholder reserves at end of year: (1		-					_
		Claim reserves					9d(1)		_
	` '	Other reserves					9d(3)		_
	()	dends or retroactive rate refunds due. (Do n							_
10		erience-rated contracts:			<u>(-/·/</u>				Ī
		al premiums or subscription charges paid to c	arrier				10a	35841	4
	b If th	e carrier, service, or other organization incur	ed anv specific costs in c	onnection	with	the acquisition or			
	rete	ntion of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report a	amou	int	10b		
	Specify r	nature of costs.							
D	art IV	Provision of Information							-
			ation page =	ا عاد ۲ ماه	lula í	Λο Π	Yes	X No	-
		insurance company fail to provide any inform		ete Sched	iuie <i>F</i>	٦٢	1 69	NO	_
12	12 If the answer to line 11 is "Yes," specify the information not provided.								

A Name of plan IEALTH BENEFIT PLAN FOR EMPLOYEES OF UNIVERSITY HEALTH, INC. Plan sponsor's name as shown on line 2a of Form 5500 INIVERSITY HEALTH, INC. D Employer Identification Number (EIN) 58-1581102 Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. Coverage Information: (b) EIN (c) NAIC code identification number persons covered at end of policy or contract year of the surfication information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid D Employer Identification Number (EIN) S8-1581102 Policy or contract year persons overed at end of persons covered at end of policy or contract year persons in descending order of the amount paid. (b) EIN (c) NAIC (d) Contract or identification number of persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid D Employer Identification Number (EIN) S8-1581102 Persons receiving commissions or fees were paid D Employer Identification Number (EIN) S8-1581102 D Employer Identification Number (EIN) S8-1581102 D Employer Identification Number (EIN) S8-1581102 Policy or contract year person to whom commissions or fees were paid D Employer Identification Number (EIN) S8-1581102 D Employer Identifica	SCHEDULE A Insurance Information		Insuranc	e Information		OI	MB No. 1210-0110		
Employee Retirement Income Socurity Act of 1974 (ERISA). Department of Labor Employee Bondts Socurity Administration File as an attachment to Form 5500. Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). A Name of plan HEALTH BENEFIT PLAN FOR EMPLOYEES OF UNIVERSITY HEALTH, INC. Plan sponsor's name as shown on line 2a of Form 5500 Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. Coverage Information: (a) Name of Jean (b) EIN (c) NAIC Code (d) Contract or identification number FE INSURANCE COMPANY OF NORTH AMERICA (b) EIN (c) NAIC Code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year Persons covered at end of policy or contract year (f) From (g) To persons overed at end of policy or contract year Persons covered at end of policy or contract year (g) Tolal amount of commissions paid (a) Total amount paid. (b) Total amount of fees paid (c) Amount (d) Name and address of the agent, broker, or other person to whom commissions or fees were paid DEMPLOYEES ANE. (b) Amount of sales and base Commissions paid (c) Amount (d) Purpose (e) Organization commissions paid (b) Amount of sales and base Commissions paid (c) Amount (d) Purpose (e) Organization commissions paid (f) Purpose (g) Organization commissions paid (g) Amount of sales and base (g) Organization commissions paid (g) Amount of sales and base (g) Organization commissions paid (g) Purpose (g) Organization commissions paid (g) Organization commissions paid (g) Organization commissions paid (g)		=	This schodule is required	to be filed under section 104	of the				
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(b) Amount of sales and base commissions paid

(c) Amount

(d) Purpose

(e) Organization code

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule A (Form 5500) 2018 v. 171027

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Schedule A (Form 5500)) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
()		,,	
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(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
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(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
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		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Page 3

F	Part					
		Where individual contracts are provided, the entire group of such individual	dual contracts v	with each carrier may	be treated	d as a unit for purposes of
1	Curr	this report. ent value of plan's interest under this contract in the general account at year e	and		4	
		ent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:	iu		<u> </u>	
Ü	a	State the basis of premium rates				
	u	otate the basis of prefilidin rates.				
	b	Premiums paid to carrier		Г	6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con		F		
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	l annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan chec	ck here		
7		tracts With Unallocated Funds (Do not include portions of these contracts mai				
•			te participation	· ·		
	а		te participation	guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
				Г		
	b	Balance at the end of the previous year			7b	С
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		г	7c(6)	С
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	C
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				

Balance at the end of the current year (subtract line 7e(5) from line 7d)

7f

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Schedule A	(Form 5500)	2018 (
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P	art III	Welfare Benefit Contract Information If more than one contract covers the same		e same emn	lover(s) or members of	the same e	mnlovee organizations(s)
		the information may be combined for report	ing purposes if such cont	racts are ex	perience-rated as a uni	t. Where co	ontracts cover individual
		employees, the entire group of such individ	ual contracts with each ca	arrier may be	e treated as a unit for p	urposes of t	his report.
8	Benefit	and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision		d X Life insurance
	e ∏ -	Temporary disability (accident and sickness)	f X Long-term disabili	ty g	Supplemental unem	ployment	h Prescription drug
	i ∏ s	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
		Other (specify) SUPP LIFE, DEP LIFE, ACC	- 🗆	L			□ ,
		Other (specify) FOOTT EITE, BET EITE, ACC	IDENTAL DEATT AND L	JIOIVILIVIDLI	CIVILIAI		
9	Experie	ence-rated contracts:					
-	•	emiums: (1) Amount received		9a(1)			
) Increase (decrease) in amount due but unpaid					
	٠,) Increase (decrease) in unearned premium res					
	(4)) Earned ((1) + (2) - (3))				. 9a(4)	0
	b Be	enefit charges (1) Claims paid		9b(1)			
	(2)	Increase (decrease) in claim reserves		9b(2)			
	(3)	Incurred claims (add (1) and (2))				. 9b(3)	0
	(4)	Claims charged				. 9b(4)	
	C Re	emainder of premium: (1) Retention charges (o	n an accrual basis)	r	T		
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees					_
		(C) Other specific acquisition costs		0.74170			
		(D) Other expenses		0-/4\/E\			
		(E) Taxes		A (4)(=)			_
		(F) Charges for risks or other contingencies		0-/4\/0\			_
		(G) Other retention charges(H) Total retention				9c(1)(H)	0
	(2	()	_	_			
		 Dividends or retroactive rate refunds. (These ratus of policyholder reserves at end of year: (1 					
) Claim reserves					
) Other reserves				9d(3)	
	`	vidends or retroactive rate refunds due. (Do n					
10		xperience-rated contracts:	or morado amount omoroc		. ,.,	., ••	
		otal premiums or subscription charges paid to c	arrier			. 10a	2753203
	b If	the carrier, service, or other organization incur	ed any specific costs in c	onnection w	ith the acquisition or		
	re	tention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report am	ount	. 10b	
		nature of costs.					
D	art IV	Provision of Information					
			-#: · · ·	-t- O		Voc	V No
		e insurance company fail to provide any inform		ete Schedul	e A?	Yes	X No
12	12 If the answer to line 11 is "Yes," specify the information not provided.						

SCHEDULE A **Insurance Information** OMB No. 1210-0110 (Form 5500) This schedule is required to be filed under section 104 of the Department of the Treasury Internal Revenue Service 2018 Employee Retirement Income Security Act of 1974 (ERISA). Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500. Pension Benefit Guaranty Corporation Insurance companies are required to provide the information This Form is Open to Public pursuant to ERISA section 103(a)(2). Inspection 12/31/2018 For calendar plan year 2018 or fiscal plan year beginning and ending 01/01/2018 A Name of plan В Three-digit HEALTH BENEFIT PLAN FOR EMPLOYEES OF UNIVERSITY HEALTH, INC. 501 plan number (PN) C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) UNIVERSITY HEALTH, INC. 58-1581102 Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract Part I on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier UNITED HEALTHCARE (AARP) (e) Approximate number of Policy or contract year (c) NAIC (d) Contract or (b) EIN persons covered at end of code identification number **(g)** To (f) From policy or contract year 36-2739571 79413 01/01/2018 12/31/2018 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (b) Amount of sales and base (d) Purpose (e) Organization code commissions paid (c) Amount

	,		,
(b) Amount of sales and base	F	ees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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Schedule A (Form 5500) 2018 v. 171027

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Schedule A (Form 5500)) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
()		,,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(-7		code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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F	Part	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indiv	idual contrac	cts with each carrier ma	y be treated a	s a unit for purposes of
1	Curr	this report.	and		4	
<u>4</u>		ent value of plan's interest under this contract in the general account at year			5	
6		ent value of plan's interest under this contract in separate accounts at year e tracts With Allocated Funds:	11 u		5	
U	a	State the basis of premium rates				
	u	otate the basis of premium rates **				
	b	Premiums paid to carrier			6b	
	c	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in co				
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan	heck here		
7		·	<u> </u>			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma		ion guarantee		
	а			ion guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	_ ` /			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	0
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account				
		(4) Other (specify below)	7e(4)			
		>				
					70(F)	

Balance at the end of the current year (subtract line 7e(5) from line 7d)

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Schedule A (Form 5500) 2018

P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
8	Rene	efit and contract type (check all applicable boxes)					<u>'</u>
	_	,		٦.	Vision	d	Life insurance
	<u> </u>			౼			
	е	Temporary disability (accident and sickness) f Long-term disabili	-	g 📙		nent n	Prescription drug
	i	Stop loss (large deductible) j HMO contract		k 📗	PPO contract	ı	Indemnity contract
	m	Other (specify)					
9	Expe	rience-rated contracts:					
	a F	Premiums: (1) Amount received	. 9a(1)				
		(2) Increase (decrease) in amount due but unpaid	9a(2)				
		(3) Increase (decrease) in unearned premium reserve	. 9a(3)				
		(4) Earned ((1) + (2) - (3))			g	a(4)	0
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves			T		
		(3) Incurred claims (add (1) and (2))				b(3)	0
		(4) Claims charged			<u>9</u>	b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual basis)					
		(A) Commissions	9c(1)(A				
		(B) Administrative service or other fees	0 (4) (4				
		(C) Other specific acquisition costs					
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies	90(1)(1	.)			
		(G) Other retention charges					
		(H) Total retention		_		(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These amounts were $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	n cash, or		credited.)g	c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide				d(1)	
		(2) Claim reserves			<u>9</u>	d(2)	
		(3) Other reserves				d(3)	
	е	Dividends or retroactive rate refunds due. (Do not include amount entered	d in line 9	c(2).)	9e	
10		nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier				10a	392730
		If the carrier, service, or other organization incurred any specific costs in c retention of the contract or policy, other than reported in Part I, line 2 above city nature of costs.				10b	_
B							
	art I					, J	N.
11		the insurance company fail to provide any information necessary to comp	lete Sche	dule	A? Yes	X	No
12	2 If the answer to line 11 is "Yes," specify the information not provided.						

			_					
_	IEDULE orm 5500		Insura	nce Information	n		ON	1B No. 1210-0110
Departm Interna	nent of the Treas al Revenue Servi	ury ce		red to be filed under section Income Security Act of 19				2018
	artment of Labor efits Security Adr		File as ar	attachment to Form 55	500.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	rm is Open to Public Inspection				
For calendar p	olan year 201	18 or fiscal pla	an year beginning 01/01/2018		and er	ding 12/3	31/2018	•
A Name of pl HEALTH BEN		FOR EMPLO	DYEES OF UNIVERSITY HEALT	ΓH, INC.		e-digit number (Pl	N) •	501
C Plan spons UNIVERSITY			ne 2a of Form 5500		-	oyer Identific 1581102	cation Number	(EIN)
Part I			erning Insurance Contract A. Individual contracts grouped					
1 Coverage I	nformation:							
(a) Name of in			DMPANY					
		(c) NAIC	(d) Contract or	(e) Approximate no persons covered a		end of		ontract year
(4)		code	identification number	policy or contrac		(f) From		(g) To
6-0307623		85766	89947	7652	2	01/01/201	8	12/31/2018
		mission inforn amount paid	nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in
	(a) Total a	mount of con	nmissions paid		(b) To	otal amount	of fees paid	
			126819					0
3 Persons re	ceiving comr	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
CRISURE IN	SURANCE	(a) Name		er, or other person to who HILLCREEK DRIVE USTA, GA 30909	m commiss	ions or fees	s were paid	
(b) Amour	nt of sales an	d base		ees and other commissio	ns paid			_
com	missions pai	†	(c) Amount	(d) Purpose			(e) Organization code	
		126819						3
		(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
		,,,	, ,				·	1
(b) Amour	nt of sales an	d base	F	ees and other commissio	ns paid			_

(d) Purpose

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

(c) Amount

commissions paid

Schedule A (Form 5500) 2018 v. 171027

(e) Organization code

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Schedule A (Form 5500)) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
()		,,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(-7		code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Page 3

F	Part	II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indiv	idual contrac	cts with each carrier ma	y be treated a	s a unit for purposes of
1	Curr	this report.	and		4	
<u>4</u>		ent value of plan's interest under this contract in the general account at year			5	
6		ent value of plan's interest under this contract in separate accounts at year e tracts With Allocated Funds:	11 u		5	
U	a	State the basis of premium rates				
	u	otate the basis of premium rates **				
	b	Premiums paid to carrier			6b	
	c	Premiums due but unpaid at the end of the year				
	d	If the carrier, service, or other organization incurred any specific costs in co				
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan	heck here		
7		·	<u> </u>			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma		ion guarantee		
	а			ion guarantee		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	_ ` /			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	0
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account				
		(4) Other (specify below)	7e(4)			
		>				
					70(F)	

Balance at the end of the current year (subtract line 7e(5) from line 7d)

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Schedule A (Form 5500) 2018

Part III Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group of employees of the ng purposes if such conti	acts are exp	erience-rated as a unit	. Where contr	acts cover individual
8 Benefit and contract type (check all applicable boxes)					
a Health (other than dental or vision)	b X Dental	С	Vision	d	Life insurance
e Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	oloyment h	Prescription drug
i Stop loss (large deductible)	j HMO contract		PPO contract	Í	☐ Indemnity contract
		•• _	110001111101	•	
m ☐ Other (specify) ▶					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)		2498312	
(2) Increase (decrease) in amount due but unpaid		9a(1)		2490312	
(3) Increase (decrease) in unearned premium res		9a(3)			
(4) Earned ((1) + (2) - (3))	·	. , ,		9a(4)	2498312
b Benefit charges (1) Claims paid				1895411	2.000.12
(2) Increase (decrease) in claim reserves				88948	
(3) Incurred claims (add (1) and (2))		. , ,		9b(3)	1984359
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (or					
(A) Commissions		9c(1)(A)		126819	
(B) Administrative service or other fees		9c(1)(B)		185070	
(C) Other specific acquisition costs		9c(1)(C)			
(D) Other expenses		9c(1)(D)			
(E) Taxes		9c(1)(E)		81195	
(F) Charges for risks or other contingencies		9c(1)(F)		24983	
(G) Other retention charges		9c(1)(G)		49866	
(H) Total retention				9c(1)(H)	467933
(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)	
(2) Claim reserves				9d(2)	158749
(3) Other reserves				9d(3)	
e Dividends or retroactive rate refunds due. (Do no	t include amount entered	l in line 9c(2)	.)	9e	
10 Nonexperience-rated contracts:					
a Total premiums or subscription charges paid to ca	arrier			10a	
b If the carrier, service, or other organization incurretention of the contract or policy, other than repospecify nature of costs.	ed any specific costs in corted in Part I, line 2 abov	onnection wit e, report amo	h the acquisition or ount	10b	
Part IV Provision of Information					
11 Did the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	А?П	Yes X	No
12 If the answer to line 11 is "Yes," specify the information		5.5 Sonoune			

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2018

Employee Retirement Income Security Act of 1974 (ERISA).		2010					
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 5500.				
Pension Benefit Guaranty C	orporation	Insurance companies a pursuant to E	re required to provide the RISA section 103(a)(2).		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 20)18 or fiscal plai	n year beginning 01/01/2018		and en	ding 12/3	31/2018	-
A Name of plan HEALTH BENEFIT PLAN	N FOR EMPLOY	YEES OF UNIVERSITY HEALTH,	, INC.		e-digit number (PI	N) •	501
C Plan sponsor's name UNIVERSITY HEALTH, I		e 2a of Form 5500			yer Identific 1581102	ation Numbe	r (EIN)
		rning Insurance Contract a. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		NY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or	contract year
(D) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
41-0451140	67105	690511	2305 01/01/2018		8	12/31/2018	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents,	brokers, and	other persons in
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees paid	
		224602					29370
3 Persons receiving con	nmissions and f	ees. (Complete as many entries a	as needed to report all p	persons).			
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
ACRISURE LLC			RAIRE CREED DRIVE S ONIA, MI 49316	SE			
(b) Amount of sales a	nd base	Fees	s and other commission	s paid			
commissions pa		(c) Amount	(d) Purpos	е		(e) Organization code
	190156						3
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
HODGES - MACE BENEF	FITS GROUP IN		GLENRIDGE DRIVE, S TA, GA 30328	SUITE 350			
(b) Amount of sales a	nd base	Fee	s and other commission	s paid			
commissions pa		(c) Amount		d) Purpos	e		(e) Organization code
	26314	29370 SE	ERVICE FEE				3
For Paperwork Reduction	on Act Notice,	see the Instructions for Form 5	500.			Sch	edule A (Form 5500) 2018

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(a) Nar	ne and address of the agent broker	r, or other person to whom commissions or fees were paid	
ENEFIT ADVISORS SERVICE GRO	OUP LLC 1120	SANCTUARY PKWY SUITE 300 IARETTA, GA 30097	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid) Amount of sales and base		
8132			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(I-) A		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of calca and hear		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			·

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Schedule A (Form 5500) 2018

Page 3

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts wit	h each carrier may be treated a	as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
		tracts With Allocated Funds:		1	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	•	,	
	а	Type of contract: (1) deposit administration (2) immedia	ate participation gu	ıarantee	
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	_ , ,		
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	(
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		>			
		(5) Total deductions		7e(5)	0

Balance at the end of the current year (subtract line 7e(5) from line 7d)

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Schedule A (Form 5500) 2018

P	art III	Welfare Benefit Contract Information If more than one contract covers the same		samo om	nlov	or(s) or mombors of	the same o	mplovoo organizations(s)
		the information may be combined for report	ing purposes if such cont	racts are e	xperi	ience-rated as a uni	t. Where co	ontracts cover individual
		employees, the entire group of such individ	ual contracts with each ca	arrier may b	be tre	eated as a unit for p	urposes of t	his report.
8	Benefit a	and contract type (check all applicable boxes)						
	а 🗌 н	ealth (other than dental or vision)	b Dental	С	۱ 🗌 :	Vision		d Life insurance
	e X T	emporary disability (accident and sickness)	f Long-term disabilities	ty g	ı∏ :	Supplemental unem	ployment	h Prescription drug
	i ∏s	top loss (large deductible)	j HMO contract	k	. □ ו	PPO contract		I Indemnity contract
		other (specify) ▶ACCIDENT, CRITICAL ILLN	- 🗆		ш			
	🔼 🔾	MIGI (Specify) PACCIDENT, ORTHORE IEEN	200					
9	Experien	ce-rated contracts:						
-	•	niums: (1) Amount received		9a(1)				
		Increase (decrease) in amount due but unpaid						
	, ,	Increase (decrease) in unearned premium res						
	` '	Earned ((1) + (2) - (3))					9a(4)	C
		nefit charges (1) Claims paid						
	(2)	Increase (decrease) in claim reserves		9b(2)				
		Incurred claims (add (1) and (2))					9b(3)	C
	(4)	Claims charged					9b(4)	
	C Rei	mainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)	.)			
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs		9c(1)(C)	_			
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)	_			
		(F) Charges for risks or other contingencies		9c(1)(F) 9c(1)(G)				
		(G) Other retention charges					9c/1\/U\	
	(2)	(H) Total retention	_	_	_		9c(1)(H)	
		Dividends or retroactive rate refunds. (These		L				
		tus of policyholder reserves at end of year: (1						
		Claim reserves					9d(2)	
	()	Other reservesidends or retroactive rate refunds due. (Do n					9d(3) 9e	
10		perience-rated contracts:	or moldde amount entered	1 111 111110 301	(∠) .).		. 36	
		al premiums or subscription charges paid to c	arrier				. 10a	1267709
	_	ne carrier, service, or other organization incuri						1201100
	rete	ention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report a	mour	nt	. 10b	
		nature of costs.	·	•				•
_	12 <i>f</i>	Dunyinian of Information						
	art IV	Provision of Information						
		insurance company fail to provide any inform		ete Schedi	ule A	.?	Yes	X No
12	If the a	nswer to line 11 is "Yes," specify the informati	on not provided.					

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2019

Pension Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	blic
Part I Ar	nual Report Ide	ntification Information				
For calendar pla	an year 2019 or fiscal	plan year beginning 01/01/2019	and ending 12/31/20	19		
A This return/re	eport is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accord			ns.)
		X a single-employer plan	a DFE (specify)			
B This return/r	eport is:	the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12	months)	
C If the plan is	a collectively-bargain	ed plan, check here			• [
D Check box if	filing under:	Form 5558	automatic extension	th	e DFVC program	
Part II Ba	sic Plan Informa	ation—enter all requested informatio	on			
1a Name of pla		PLOYEES OF UNIVERSITY HEALTH	I. INC.	1b	Three-digit plan number (PN) ▶	501
			,	1c	1c Effective date of plan 01/01/1969	
Mailing add City or towr	lress (include room, a n, state or province, co	if for a single-employer plan) pt., suite no. and street, or P.O. Box) ountry, and ZIP or foreign postal code	e (if foreign, see instructions)	2b	Employer Identifica Number (EIN) 58-1581102	tion
UNIVERSITY H	2c	2c Plan Sponsor's telephone number 706-722-9011				
1350 WALTON WAY AUGUSTA, GA 30901			2d	2d Business code (see instructions) 622000		

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	08/18/2020 Date	DAVID BELKOSKI Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2019) v. 190130

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	Form 5500 (2019)	Pa	ge 2			
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Admin	istrator's EIN	
				3c Administrator's telephone		
				numb	er	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin	nce the last ret	urn/report filed for this plan,	4b EIN		
_	enter the plan sponsor's name, EIN, the plan name and the plan number from			4d PN		
a C	Sponsor's name Plan Name			4u PN		
5	Total number of noticinants at the hearinning of the plan year				0047	
6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated	d (welfare plans	s complete only lines 6a(1)	5	6047	
·	6a(2), 6b, 6c, and 6d).	a (wenare plan	s complete only lines ou(1),			
a(1) Total number of active participants at the beginning of the plan year			6a(1)	5818	
Ì					5657	
a(2) Total number of active participants at the end of the plan year			6a(2)		
b	Retired or separated participants receiving benefits			6b	141	
С	Other retired or separated participants entitled to future benefits			6c	0	
A	Subtotal. Add lines 6a(2) , 6b , and 6c			6d	5798	
d	Subtotal. Add lines ba(2), bb, and bc			6 u	3730	
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits.		6e		
f	Total. Add lines 6d and 6e			6f		
g	Number of participants with account balances as of the end of the plan year	(only defined c	ontribution plans			
Ū	complete this item)			6g		
h	Number of participants who terminated employment during the plan year with					
7	less than 100% vested			6h 7		
	If the plan provides pension benefits, enter the applicable pension feature co		<u> </u>		tructions:	
b	If the plan provides welfare benefits, enter the applicable welfare feature cod	les from the Lis	st of Plan Characteristics Code	es in the instr	uctions:	
	4A 4B 4D 4E 4F 4H 4Q					
9a	Plan funding arrangement (check all that apply)	Qh Dian ha	nefit arrangement (check all th	ect apply)		
Ja	(1) X Insurance	(1)	Insurance	іат арріу)		
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance c	ontracts	
	(3) Trust	(3)	Trust			
40	(4) X General assets of the sponsor	(4)	General assets of the s	•		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ittacned, and, v	vnere indicated, enter the num	ber attached	i. (See instructions)	
а	Pension Schedules		al Schedules			
	(1) R (Retirement Plan Information)	(1)	H (Financial Infor	,	11.DL	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Infor		ali Plan)	
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X 4 A (Insurance Info	•	,	
	actuary	(4)	C (Service Provid		•	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participa	•	,	
	Information) - signed by the plan actuary	(6)	G (Financial Tran	saction Sche	edules)	

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SCHEDULE A (Form 5500)

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

Employee Retirement Income Security Act of 1974 (ERISA).			2019				
Department of Labo Employee Benefits Security Ad		File as a	n attachment to Form 55	500.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This F			This For	m is Open to Public Inspection			
For calendar plan year 20	19 or fiscal plan	n year beginning 01/01/2019		and er	ding 12/	31/2019	•
A Name of plan		, ,		B Thre	e-digit		
HEALTH BENEFIT PLAN FOR EMPLOYEES OF UNIVERSITY HEAL			.TH, INC.		number (Pl	N) •	501
						,	
C Plan sponsor's name a	as shown on line	e 2a of Form 5500		D Emplo	yer Identific	cation Number	(EIN)
UNIVERSITY HEALTH, I				-	-1581102		,
		rning Insurance Contra					
1 Coverage Information:		U I					
(a) Name of insurance ca	rrier						
HUMANA INSURANCE C	OMPANY						
			(e) Approximate n	umber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of		(f)		
	code	identification number	policy or contrac	policy or contract year		From	(g) To
39-1263473	73288	736882	2552 01/01/2019		12/31/2019		
2 Insurance fee and com descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comi	missions paid		(b) To	otal amount	of fees paid	
		46782					8789
3 Persons receiving com	missions and fe	ees. (Complete as many entri	es as needed to report all	persons).			
		and address of the agent, broke			ions or fees	were paid	
ACRISURE LLC DBA HEA	AD CAPITAL	2840	HILLCREEK DRIVE				
		AUG	GUSTA, GA 30909				
							T
(b) Amount of sales ar			ees and other commissio				
commissions pa		(c) Amount	COMMISSIONS	(d) Purpos	e		(e) Organization code
	31193	0	COMMISSIONS	COMMISSIONS			3
	(=\ \ \ \ = = = = = =		4h				
TUOMA ON MANYER	(a) Name a	and address of the agent, broke	•	m commiss	ions or tees	s were paid	
THOMAS W. MAYER			TH ST E STE 500 NT PAUL, MN 55101				
		3 ,					
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	15589	0	COMMISSIONS				3

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule A (Form 5500) 2019 v. 190130

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Schedule A (Form 5500) 2019 Page **2** -(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid ACRISURE LLC DBA ACHS INSURANCE 1201 TOWN PARK LANE **EVANS. GA 30809** Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 0 8789 **BONUS** 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (d) Purpose (c) Amount commissions paid code

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Schedule A (Form 5500) 2019

Page 3

ı	Part	II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contrad	cts with each carrier may	be treated	l as a unit for purposes of
			this report.				
			alue of plan's interest under this contract in the general account at year			4	
5	Curr	ent v	alue of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con		s With Allocated Funds:				
	а	Stat	te the basis of premium rates				
	b	Dro	miums paid to carrier			6b	
	_		miums due but unpaid at the end of the year			6c	
	c d		e carrier, service, or other organization incurred any specific costs in co				
	-		ntion of the contract or policy, enter amount.			6d	
		Spe	cify nature of costs				
	е	Тур	e of contract: (1) individual policies (2) group deferre	d annuity			
		(3)	other (specify)				
					. 🗖		
_	f		ontract purchased, in whole or in part, to distribute benefits from a termin				
7	Con		s With Unallocated Funds (Do not include portions of these contracts ma		•		
	а	Тур	e of contract: (1) 🔲 deposit administration (2) 📙 immedia	ate participat	ion guarantee		
			(3) guaranteed investment (4) other	•			
			-				
	b	Bala	ance at the end of the previous year			7b	0
	С	Add	litions: (1) Contributions deposited during the year	. 7c(1)			
		(2) [Dividends and credits	7c(2)			
		(3) I	Interest credited during the year	7c(3)			
		(4)	Transferred from separate account	. 7c(4)			
		(5)	Other (specify below)	7c(5)			
		È					
		(6)T	otal additions			7c(6)	0
	d	` '	I of balance and additions (add lines 7b and 7c(6)).			7d	0
			uctions:	Γ			
			Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
			Administration charge made by carrier	7e(2)			
		` '	ransferred to separate account	7e(3)			
		` '	Other (specify below)	7e(4)			
		(·) C	() 201011/	(- /)			
		•					
			otal deductions			7e(5)	0

Balance at the end of the current year (subtract line 7e(5) from line 7d)

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Schedule A (Form 5500) 2019

P	Part III	Welfare Benefit Contract Information one contract covers the same		o samo or	mnlo	vor(s) or mombors of	the same o	mplovoo organizations	·(c)
		the information may be combined for report							
		employees, the entire group of such individ							
8	Benefit a	nd contract type (check all applicable boxes)							
	а П не	ealth (other than dental or vision)	b Dental		c X	Vision		d Life insurance	
	e	mporary disability (accident and sickness)	f Long-term disabili	ty (g 🗍	Supplemental unem	ployment	h Prescription dru	g
	i ☐ Ste	op loss (large deductible)	j HMO contract		_ =	PPO contract		I Indemnity contra	act
		her (specify)	• 🗆		ш			, ,	
	🗆 🖰	iner (specify)							
9	Experienc	ce-rated contracts:							
•	•	iums: (1) Amount received		9a(1)					
		ncrease (decrease) in amount due but unpaid							
		ncrease (decrease) in unearned premium res							
	` '	Earned ((1) + (2) - (3))					9a(4)		0
		efit charges (1) Claims paid							
	(2) Ir	ncrease (decrease) in claim reserves		9b(2)					
		ncurred claims (add (1) and (2))					. 9b(3)		0
	(4) C	Claims charged					9b(4)		
	C Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)						
		(A) Commissions		9c(1)(A	۱)				
	((B) Administrative service or other fees							
		(C) Other specific acquisition costs							
		(D) Other expenses		0 - /4 \ / E					
		(E) Taxes		A (4) (=					
		(F) Charges for risks or other contingencies		0-14116				_	
		(G) Other retention charges					0o/4\/LI\	\	0
		(H) Total retention			_		9c(1)(H)	1	0
		Dividends or retroactive rate refunds. (These	<u></u>		_				
		us of policyholder reserves at end of year: (1	•				· · · ·		
	` '	Claim reserves					9d(2)		
	()	Other reservesdends due. (Do no					9d(3) 9e		
10		erience-rated contracts:	or include amount entered	ı III IIII 3	C(Z).)	. 36		
	•	al premiums or subscription charges paid to c	arrier				. 10a		339790
	_						. 100		000100
	rete	e carrier, service, or other organization incurr ntion of the contract or policy, other than repo	orted in Part I. line 2 abov	e. report	ı wıu amoı	unt	. 10b		
	Specify r	nature of costs.	,	-,				'	
P	Part IV	Provision of Information							
11	Did the	insurance company fail to provide any inform	ation necessary to comp	lete Sche	dule.	A?	Yes	X No	
12	If the ar	nswer to line 11 is "Yes," specify the informati	on not provided.						

SCHEDULE A (Form 5500)

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

0040

Internal Revenue Ser	vice	Employee Retirement Income Security Act of 1974 (ERISA).					2019
Department of Lab Employee Benefits Security A		File as an attachment to Form 5500.					
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					This For	m is Open to Public Inspection	
For calendar plan year 20	019 or fiscal pla	n year beginning 01/01/2019		and er	ding 12/	31/2019	-
A Name of plan				B Thre	e-digit		
HEALTH BENEFIT PLA	N FOR EMPLO	YEES OF UNIVERSITY HEALT	H, INC.	plan	number (Pl	N) •	501
C Plan sponsor's name	as shown on lin	e 2a of Form 5500		D Emplo	ver Identific	ation Number	(EIN)
UNIVERSITY HEALTH,					-1581102		()
,	_						
		rning Insurance Contrac					
		A. Individual contracts grouped a	is a unil in Parls II and I	ii can be re	ported on a	single Schedu	Ie A.
1 Coverage Information:							
(a) Name of insurance ca	arrier						
LIFE INSURANCE COMP	PANY OF NORT	TH AMERICA					
			(e) Approximate n	umber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	at end of	(f)	From	(g) To
			policy or contrac		()		
23-1503749	65498	FLX 98014,3-4*	5365		01/01/201	9	12/31/2019
2 Insurance fee and con descending order of th		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and c	ther persons in
	amount of com	missions paid		(b) To	otal amount	of fees paid	
		172747					33292
3 Persons receiving con	nmissions and f	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
LOCKTON COMPANIES	, LLC		3042 OX 123042 AS, TX 75312				
		For	as and other commission	ne naid			
(b) Amount of sales a commissions page		(c) Amount	es and other commissio	and other commissions paid (d) Purpose			(e) Organization code
CONTINUCCIONO PO	172747	` '	SALES AND SERVICE (LES AND SERVICE OVERRIDE			3
	(a) Name a	and address of the agent, broker,	, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	and base	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
For Paperwork Reduction	on Act Notice,	see the Instructions for Form	5500.			Sche	dule A (Form 5500) 2019

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Schedule A (Form 5500)	2019	Page 2 – 1				
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
Fees and other commissions paid						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
1						
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	•			
, ,	•					
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization code			
commissions paid	(*)		code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(a) Hai	no ana adaroso er are agent, broker	, or early person to minim commissions or rose here para				
	Г	2				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid I	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(h) Amount of calca and bear		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

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Ī	Part	II Investment and Annuity Contract Information							
		Where individual contracts are provided, the entire group of such indiv	idual contra	cts with each carrier may	y be treated	I as a unit for purposes of			
1	Cur	this report.	and		4				
5		ent value of plan's interest under this contract in the general account at year			5				
6	_	ent value of plan's interest under this contract in separate accounts at year e tracts With Allocated Funds:	iiu						
٠	a	State the basis of premium rates							
	u	otate the basis of premium rates 7							
	b	Premiums paid to carrier			6b				
	C	Premiums due but unpaid at the end of the year			6c				
	d	If the carrier, service, or other organization incurred any specific costs in co							
	-	retention of the contract or policy, enter amount.			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) other (specify)							
		(4) [] (
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check here					
7		tracts With Unallocated Funds (Do not include portions of these contracts ma							
•				tion guarantee					
	а		ite participa	tion guarantee					
		(3) ☐ guaranteed investment (4) ☐ other ▶							
	_								
	b	Balance at the end of the previous year			. 7b	0			
	С	Additions: (1) Contributions deposited during the year	_ ` /						
		(2) Dividends and credits	- (0)						
		(3) Interest credited during the year							
		(4) Transferred from separate account							
		(5) Other (specify below)	7c(5)						
		•							
		(6)Total additions			7c(6)	0			
	d	Total of balance and additions (add lines 7b and 7c(6))	г		. 7d	0			
	е	Deductions:							
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)						
		(2) Administration charge made by carrier							
		(3) Transferred to separate account							
		(4) Other (specify below)	7e(4)						
		>							
		(5) Total deductions			7e(5)				

f Balance at the end of the current year (subtract line 7e(5) from line 7d)

7f

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Schedule A (Form 5500) 2019

D till Wolfers Donafit Contract lafe was					
Part III Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the	racts are exp	perience-rated as a un	it. Where conti	racts cover individual
8 Benefit and contract type (check all applicable boxes)					_ •
	b Dental	сГ	Vision	d	X Life insurance
	블	L	=		
e Temporary disability (accident and sickness)	f X Long-term disabili	ty g _	Supplemental unem	iployment h	Prescription drug
i Stop loss (large deductible)	j HMO contract	k	PPO contract	I	Indemnity contract
m X Other (specify) ▶ SUPP LIFE, DEP LIFE, ACC	IDENTAL DEATH AND	DISMEMBER	RMENT		
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpaid.					
(3) Increase (decrease) in unearned premium rese		- (-)			
(4) Earned ((1) + (2) - (3))				9a(4)	0
b Benefit charges (1) Claims paid				.,(/	
(2) Increase (decrease) in claim reserves					
(3) Incurred claims (add (1) and (2))				9b(3)	0
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (on			•••••	5.5(1)	
(A) Commissions	,	9c(1)(A)			
(B) Administrative service or other fees					
(C) Other specific acquisition costs		2 (1)(2)			
(D) Other expenses		0 (4)(5)			
(E) Taxes		0-(4)(5)			
(F) Charges for risks or other contingencies		0 (4)(5)			
(G) Other retention charges		0 (4)(0)			
(H) Total retention				9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These					
		<u> </u>			
d Status of policyholder reserves at end of year: (1)	·			· · ·	
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
Dividends or retroactive rate refunds due. (Do not	include amount entered	a in line 9c(2)	<u>).)</u>	9e	
10 Nonexperience-rated contracts:				- 10	
Total premiums or subscription charges paid to ca	rrier			10a	2559459
b If the carrier, service, or other organization incurre retention of the contract or policy, other than report Specify nature of costs.				10b	
Part IV Provision of Information					
				l., 🖂	•••
11 Did the insurance company fail to provide any informa		lete Schedule	e A?	Yes X	No
12 If the answer to line 11 is "Yes," specify the information	n not provided.				

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2019

Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	19 or fiscal pla	n year beginning 01/01/2019		and en	ding 12/3	31/2019	
A Name of plan HEALTH BENEFIT PLAN	N FOR EMPLO	OYEES OF UNIVERSITY HEALTI	H, INC.		e-digit number (PI	N) •	501
C Plan sponsor's name a UNIVERSITY HEALTH, I	NC.			58-	1581102	eation Number	` '
		rning Insurance Contract A. Individual contracts grouped a					
1 Coverage Information:		J 1				3	
(a) Name of insurance ca		_					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year
(D) EIN	code	identification number	policy or contrac		(f)	From	(g) To
36-2739571	79413	0	265		01/01/201	9	12/31/2019
descending order of the	amount paid.	ation. Enter the total fees and tot	al commissions paid. L			,	ther persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
3 Parsons receiving com	missions and t	fees. (Complete as many entries	as needed to report all	nereone)			
• 1 craona receiving com		and address of the agent, broker,			ions or fees	were paid	
							T
(b) Amount of sales ar		(c) Amount	es and other commission	ns paid (d) Purpos	•		(e) Organization code
commissions pa	la	(c) Amount		(u) Purposi	3		(e) Organization code
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
			·				
(b) Amount of sales ar	nd hase	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
For Panerwork Reduction	n Act Notice	see the Instructions for Form !	5500			School	dule A (Form 5500) 2019

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Schedule A (Form 5500)	2019	Page 2 – 1				
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
Fees and other commissions paid						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
1						
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	•			
, ,	•					
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization code			
commissions paid	(*)		code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(a) Hai	no ana adaroso er are agent, broker	, or early person to minim commissions or rose here para				
	Г	2				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid I	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(h) Amount of calca and bear		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

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Schedule A (Form 5500) 2019

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Part I		II Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indiv	idual contra	acts with each carrier may	be treated	d as a unit for purposes of
1	Cur	this report. ent value of plan's interest under this contract in the general account at year	end		4	
5		ent value of plan's interest under this contract in the general accounts at year e			5	
6	_	racts With Allocated Funds:	11u		J	
٠	a	State the basis of premium rates				
	~	otate the basis of promitin rates 7				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co				
	-	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts ma				
•	a			ition guarantee		
	u			aion guarantos		
		(3) guaranteed investment (4) other				
	L				71-	
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	- (0)			
		(3) Interest credited during the year	- (4)			
		(4) Transferred from separate account				
		(5) Other (specify below)	10(3)			
		(6)Total additions				0
		Total of balance and additions (add lines 7b and 7c(6))			. 7d	0
	е	Deductions:	7.(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	_ ` _			
		(3) Transferred to separate account.				
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			7e(5)	0

Balance at the end of the current year (subtract line 7e(5) from line 7d)

7f

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Schedule A (Form 5500) 2019

Part III Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ng purposes if such cont	racts are ex	perience-rated as a	unit. Where cor	ntracts cover individual
8 Benefit and contract type (check all applicable boxes)					
a X Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental un	employment	h Prescription drug
i Stop loss (large deductible)	j HMO contract		PPO contract		I Indemnity contract
m ☐ Other (specify) ▶	, L	L			□ ,
III Utilet (specify)					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpaid					
(3) Increase (decrease) in unearned premium res					-
(4) Earned ((1) + (2) - (3))				9a(4)	0
b Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))				9b(3)	0
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (o	n an accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees					
(C) Other specific acquisition costs					_
(D) Other expenses					-
(E) Taxes		A (4)(E)			
(F) Charges for risks or other contingencies		0-/4\/0\			
(G) Other retention charges				0o(1)(U)	0
(H) Total retention	_			```	0
(2) Dividends or retroactive rate refunds. (These					
d Status of policyholder reserves at end of year: (1	•				
(2) Claim reserves					
(3) Other reserves				· · · ·	
10 Nonexperience-rated contracts:	n molude amount entered	u III IIIIe 30(2	-j .)	9e	
a Total premiums or subscription charges paid to c	arrier			10a	351422
					001122
b If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	ed any specific costs in c orted in Part I. line 2 abov	e. report am	nunt	10b	
Specify nature of costs.	•	, ,			
Part IV Provision of Information					
11 Did the insurance company fail to provide any inform	ation necessary to comp	lete Schedul	le A?	Yes	No No
12 If the answer to line 11 is "Yes," specify the informati	on not provided.				

SCHEDULE A (Form 5500)

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

Internal Revenue Service Employee Retirement Income Security Act of 1974 (ERISA).				2019			
Department of Labor Employee Benefits Security Adm	ninistration	File as an attachment to Form 5500.					
Pension Benefit Guaranty Cor	poration	Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2		tion		m is Open to Public Inspection
For calendar plan year 201	9 or fiscal plar	n year beginning 01/01/2019		and er	nding 12/3	1/2019	•
A Name of plan				B Thre	e-digit		
HEALTH BENEFIT PLAN	FOR EMPLO	YEES OF UNIVERSITY HEALTH	H, INC.		number (PN	n 🕨	501
					(-,	
C Plan sponsor's name as	s shown on line	e 2a of Form 5500		D Emplo	ver Identific:	ation Number	(FIN)
UNIVERSITY HEALTH, IN				-	-1581102		()
		rning Insurance Contract Individual contracts grouped a					
1 Coverage Information:		3 1					
(a) Name of insurance car							
RELIASTAR LIFE INSURA	NCE COMPAI	NY					
	() 1110	() 0	(e) Approximate n	umber of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a		(f)	From	(g) To
		idonanoanon nambor	policy or contrac	t year	(1)	1 10111	(9) 10
41-0451140	67105	69051-1	5079		9	12/31/2019	
2 Insurance fee and comn descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	mount of comi	missions paid		(b) To	otal amount	of fees paid	
		226996					24701
3 Persons receiving comm	nissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
ACRISURE LLC			PRAIRE CREED DRIVE	SE			
		CALEI	DONIA, MI 49316				
(b) Amount of sales and	d boss	Fee	es and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code
	191915	0 V	VRITING AGENT				3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
HODGES - MACE BENEFI	TS GROUP IN	NC 5775-I	O GLENRIDGE DRIVE,	SUITE 350)		
		ATLAN	NTA, GA 30328				
(b) Amount of sales and	d hase	Fee	es and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code
	27033	24701 S	SERVICE FEE				3
Fan Damanus ats Dades 10	A -4 N -4'-	one the Instructions for Form 6				0-1	dulo A (Form 5500) 2010

v. 190130

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Schedule A (Form 5500) 2019 Page **2** -(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid BENEFIT ADVISORS SERVICE GROUP LLC 1120 SANCTUARY PKWY SUITE 300 ALPHARETTA, GA 30097 Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 8048 0 **WRITING AGENT** 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code

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Schedule A (Form 5500) 2019

Page 3

I	Part	Where individual contracts are provided, the entire group of such indivi	dual contracts w	ith each carrier may t	e treated a	as a unit for purposes of
1	Curr	this report. ent value of plan's interest under this contract in the general account at year	and		4	
					5	
	Current value of plan's interest under this contract in separate accounts at year end					
U	a	State the basis of premium rates				
	u	State the basis of premium rates.				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	6d	
		retention of the contract or policy, enter amount.				
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check	k here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
-	а	<u> </u>	ite participation g			
	_		1 1 9			
		(3) ☐ guaranteed investment (4) ☐ other ▶				
	h	Delever of the condition of the condition		Г	7h	
	b	Balance at the end of the previous year		·····	7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	0
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
)	, , ,			
		,				
					- (5)	
		(5) Total deductions			7e(5)	0

Balance at the end of the current year (subtract line 7e(5) from line 7d)

7f

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Schedule A (Form 5500) 2019

P	art	Welfare Benefit Contract Informal If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	group ng pu	of urpo	oses if s	uch cor	ntracts are	exp	erience-rated as a un	it. Where co	ntrac	ts cover individual
8	Ben	efit and contract type (check all applicable boxes)					·		<u> </u>	· · · · · · · · · · · · · · · · · · ·		·
•	a [Health (other than dental or vision)	b∏	٦ ٦	ental			٦	Vision		d□	Life insurance
	L		_ =	_				_	<u></u>		. =	
	е	X Temporary disability (accident and sickness)	f∐		ong-tern				Supplemental unem	nployment	h∐	Prescription drug
	i	Stop loss (large deductible)	j∟	Н	MO con	tract		k _	PPO contract		I	Indemnity contract
	m	X Other (specify) ACCIDENT, CRITICAL ILLN	IESS									
		-										
9	Ехр	erience-rated contracts:										
	а	Premiums: (1) Amount received					9a(1))				
		(2) Increase (decrease) in amount due but unpaid					9a(2))				
		(3) Increase (decrease) in unearned premium res	erve .				9a(3)				
		(4) Earned ((1) + (2) - (3))					<u></u>			9a(4)		0
	b	Benefit charges (1) Claims paid					9b(1)				
		(2) Increase (decrease) in claim reserves					9b(2)				
		(3) Incurred claims (add (1) and (2))								9b(3)		0
		(4) Claims charged								9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an a	acc	rual bas	is)						
		(A) Commissions					9c(1)(A)				
		(B) Administrative service or other fees					9c(1)(B)				
		(C) Other specific acquisition costs					9c(1)(C)				
		(D) Other expenses					9c(1)(l	D)				
		(E) Taxes					9c(1)(l	E)				
		(F) Charges for risks or other contingencies					9c(1)(l	F)				
		(G) Other retention charges					9c(1)(G)				
		(H) Total retention								. 9c(1)(H)	1	0
		(2) Dividends or retroactive rate refunds. (These	amou	unts	s were	paid	in cash, or	٠П ,	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1			_			_				
	-	(2) Claim reserves				•						
		(3) Other reserves										
	е	Dividends or retroactive rate refunds due. (Do no										
10		nexperience-rated contracts:						-(-,	,	.,		
-	а	Total premiums or subscription charges paid to c	arrier							10a		1279431
												.2.0.0.
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo								10b		
	Spe	ecify nature of costs.	ntou i		are i, iiii	10 2 450	ro, roport	uiiic	,			
Р	art	IV Provision of Information										
11		d the insurance company fail to provide any inform	ation	nec	cessary	to com	plete Sche	dule	A?	Yes	X N	0
12		he answer to line 11 is "Yes," specify the informati										
		. ,		•								

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2020

This Form is Open to Public

Pension Benefit Guaranty Corporation	on		Inspection				
Part I Annual Report Identification Information							
For calendar plan year 2020 or	fiscal plan year beginning 01/01/2020	and ending 12/31/2	.020				
A This return/report is for:	A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this participating employer information in accordance)						
B This return/report is:	the first return/report	the final return/report					
	an amended return/report	a short plan year return/report (less than 1	2 months)				
C If the plan is a collectively-ba	argained plan, check here						
D Check box if filing under:	X Form 5558	automatic extension	the DFVC program				
_	special extension (enter description	n)	_				
Part II Basic Plan Infe	Part II Basic Plan Information—enter all requested information						
1a Name of plan HEALTH BENEFIT PLAN FO	1b Three-digit plan number (PN) ▶ 501						
TIEMENT BENEFIT FEMILES	IN EMILES (EEG OF GIAVEROUT) THEYER	1, 110.	1c Effective date of plan 01/01/1969				
Mailing address (include ro	2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)						
UNIVERSITY HEALTH, INC.	2c Plan Sponsor's telephone number 706-722-9011						
1350 WALTON WAY AUGUSTA, GA 30901	2d Business code (see instructions) 622000						

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	08/20/2021 Date	DAVID BELKOSKI Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2020) v. 200204

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	Form 5500 (2020)				
3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administrator's EIN		
			3c Administrator's telephone number		
			Humber		
4	If the name and/or EIN of the plan sponsor or the plan name has changed si	ince the last return/report filed for this plan.	4b EIN		
а	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name		4d PN		
C	Plan Name		Tu Ti		
5	Total number of participants at the beginning of the plan year		5	5915	
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d) .	d (welfare plans complete only lines 6a(1),	_		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	5741	
a(2) Total number of active participants at the end of the plan year		6a(2)	5254	
b	Retired or separated participants receiving benefits		6b	116	
С	Other retired or separated participants entitled to future benefits		6c	0	
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d	5370	
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits	6e		
f	Total. Add lines 6d and 6e		6f		
g	Number of participants with account balances as of the end of the plan year complete this item)		6g		
h	Number of participants who terminated employment during the plan year with less than 100% vested		6h		
7	Enter the total number of employers obligated to contribute to the plan (only				
8a b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan provides welfare benefits.				
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all th	at annly)		
Ju	(1) X Insurance	(1) X Insurance	apply/		
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance contra	icts	
	(3) Trust	(3) Trust			
	(4) X General assets of the sponsor	(4) X General assets of the s	•		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the num	ber attached. (So	ee instructions)	
а	Pension Schedules	b General Schedules			
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation)		
	(a)	(2) I (Financial Inform	mation – Small Pl	an)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3) X 4 A (Insurance Info	rmation)		
	actuary	(4) C (Service Provid	•		
			·	ion)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		-	-	
	Information) - signed by the plan actuary	(6) G (Financial Tran	saction Schedule	s)	

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Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2020

Employee Benefits Security Administration			File as ar	attachment to Form 55	00.			
Pension Bene	efit Guaranty Co	prporation	Insurance companies pursuant to	he information			rm is Open to Public Inspection	
For calendar p	olan year 202	20 or fiscal pla	n year beginning 01/01/2020		and en	ding 12/3	31/2020	
A Name of pl	an				B Three	e-digit		
HEALTH BEI	NEFIT PLAN	FOR EMPLO	YEES OF UNIVERSITY HEAL	TH, INC.		number (PI	N) •	501
						,	,	
C Plan spons	or's name a	s shown on lin	ne 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
UNIVERSITY HEALTH, INC. 58-1581102						·		
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for ea on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage II	nformation:							
(a) Name of in	nsurance ca			(a) Approximate pu	umbor of		Policy or co	patract year
(b) E	IN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				
(3) =		code	identification number	policy or contrac		(f)	From	(g) To
39-1263473	263473 73288 736882 2430 01/01/202		20	12/31/2020				
		mission inform amount paid.	ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
	(a) Total a	amount of com	missions paid		(b) To	tal amount	of fees paid	
	• •		53677		` '		•	4135
3 Parsons ro	coiving com	missions and f	fees. (Complete as many entrie	os as pooded to report all	noreone)			
• Telsolis le	cerving com		and address of the agent, broke			ions or fees	were naid	
ACRISURE LL	C DBA HEA		2840	HILLCREEK DRIVE USTA, GA 30909	11 00111111100	10110 01 1000	wore paid	
(b) Amoun	t of sales ar	nd base	F	ees and other commission	ns paid			
` '	missions pai		(c) Amount	(d) Purpose				(e) Organization code
		35785	0	COMMISSIONS				3
		(a) Name a	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
THOMAS W. N	MAYER			TH ST E STE 500				
			SAIN	IT PAUL, MN 55101				
(b) Amount of sales and base Fees and other commissions paid								
	missions pai		(c) Amount		(d) Purpose	<u> </u>		(e) Organization code
		17892	0	COMMISSIONS				3
Fan Bananana da B. J. W. A. 1917								<u> </u>

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule A (Form 5500) 2020 v. 200204

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 78 of 115

Schedule A (Form 5500) 2020 Page **2** -(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid ACRISURE LLC DBA ACHS INSURANCE 1201 TOWN PARK LANE **EVANS, GA 30809** Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 0 4135 **BONUS** 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (d) Purpose (c) Amount commissions paid code

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Schedule A (Form 5500) 2020

Page 3

Par		Ш	Investment and Annuity Contract Information			
			Where individual contracts are provided, the entire group of such individual	dual contracts with each carrier may	be treated	d as a unit for purposes of
4	Cur	rent v	this report. alue of plan's interest under this contract in the general account at year e	and	4	
5			alue of plan's interest under this contract in separate accounts at year er		5	
6			With Allocated Funds:	id		
٠	a		e the basis of premium rates			
	_	Ola	o the basic of profitment ratios 7			
	b	Pre	miums paid to carrier		6b	
	C		miums due but unpaid at the end of the year		6c	
	d		e carrier, service, or other organization incurred any specific costs in con			
			ntion of the contract or policy, enter amount		6d	
		Spe	cify nature of costs			
	е	Тур	e of contract: (1) individual policies (2) group deferred	I annuity		
		(3)	other (specify)			
		` ,	ш (1 7/			
	f	If co	ontract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7			With Unallocated Funds (Do not include portions of these contracts mai			
•				te participation guarantee		
	а	тур	`'	te participation guarantee		
			(3) guaranteed investment (4) other			
	b	Bala	ance at the end of the previous year		7b	(
	С		itions: (1) Contributions deposited during the year	7c(1)		
		. ,	Dividends and credits	7c(2)		
		(3)	nterest credited during the year	7c(3)		
		` '	Transferred from separate account	7c(4)		
		(5)	Other (specify below)	7c(5)		
		P				
		(6)T	otal additions		7c(6)	O
	d	Tota	of balance and additions (add lines 7b and 7c(6)).		7d	(
	е	Dedu	uctions:			
		(1) [Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) A	dministration charge made by carrier	7e(2)		
		(3) T	ransferred to separate account	7e(3)		
		(4) (Other (specify below)	7e(4)		
		•				
		/ C \ T			7o(5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (Form 5500) 2020

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such core	ntracts are experience-rated as a	unit. Where contracts c	over individual
employees, the entire group of such individual contracts with each of	carrier may be treated as a unit f	for purposes of this report	
8 Benefit and contract type (check all applicable boxes)	_	_	
a ☐ Health (other than dental or vision) b ☐ Dental	C ⋉ Vision	d ∐ Life	e insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabi	lity g Supplemental u	nemployment h Pre	escription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract	I ☐ Ind	emnity contract
m ☐ Other (specify) ▶			
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid			
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))			0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C) 9c(1)(D)		
(D) Other expenses	9c(1)(E)		
(E) Charges for risks or other centingensies	9c(1)(F)		
(F) Charges for risks or other contingencies(G) Other retention charges			
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid it			
d Status of policyholder reserves at end of year: (1) Amount held to provide	—		
(2) Claim reserves			
(3) Other reserves			
Dividends or retroactive rate refunds due. (Do not include amount entered			
10 Nonexperience-rated contracts:	· · · · · · · · · · · · · · · · · · ·	55	
a Total premiums or subscription charges paid to carrier		10a	331287
b If the carrier, service, or other organization incurred any specific costs in			
retention of the contract or policy, other than reported in Part I, line 2 abo Specify nature of costs.			
Part IV Provision of Information			
	alata Cabadula AO	☐ Yes 💢 No	
11 Did the insurance company fail to provide any information necessary to comp	olete Schedule A?	∐ řes 🔥 NO	
12 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2020

Employee Benefits Security Administration		File as an attachment to Form 5500.							
Pension Benefit Guaranty Co	prporation		rs are required to provide the information o ERISA section 103(a)(2).				n is Open to Public Inspection		
For calendar plan year 20:	20 or fiscal plar	n year beginning 01/01/2020		and en	ding 12/3	31/2020			
A Name of plan				B Thre	e-digit				
HEALTH BENEFIT PLAN	N FOR EMPLO	YEES OF UNIVERSITY HEAL	TH, INC.	plan	number (Pl	N) •	501		
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)		
UNIVERSITY HEALTH, INC. 58-1581102									
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Information:									
(a) Name of insurance ca		H AMERICA							
/b) [IN]	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	contract year		
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To		
23-1503749	-1503749 65498 FLX 98014,3-4* 7871 01/01/202		01/01/202	0	12/31/2020				
2 Insurance fee and com- descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in		
(a) Total a	amount of comr	missions paid		(b) To	otal amount	of fees paid			
		126521					32810		
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	es as needed to report all	persons).					
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid			
LOCKTON COMPANIES,	LLC	PO E	T 3042 BOX 123042 LAS, TX 75312						
(la) A manual of a class on	- d le	F	ees and other commission	ns paid					
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code		
	126521		SALES AND SERVICE C	· · · · · ·			3		
	(a) Name a	nd address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid			
(b) Amount of sales and base Fees and other commissions paid									
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code		
·				•					
For Paperwork Reduction	n Act Notice,	see the Instructions for Form	n 5500.			Sched	lule A (Form 5500) 2020		

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Schedule A (Form 5500) 2	2020	Page 2 – 1	
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
,,			
	Т		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0) / 11103111	(c) i dipose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Na	me and address of the agent hro	oker, or other person to whom commissions or fees were paid	
(u) Hui	The drie address of the agont, bre	shor, or other person to whom commissions or rece were part	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Schedule A (Form 5500) 2020

Page 3

Par			Annuity Contract						
		Where individual con this report.	tracts are provided, the	entire group of such indiv	idual contrac	cts with each carrie	r may be treated	as a unit for purposes of	
4	Curi	rent value of plan's interest	under this contract in th	e general account at year	end		4		_
5		ent value of plan's interest							_
6		tracts With Allocated Funds							_
a State the basis of premium rates									
		·							
	b	Premiums paid to carrier					6b		
	С	Premiums due but unpaid	at the end of the year.				6с		
	d	If the carrier, service, or of retention of the contract of							
		Specify nature of costs	•						
	е	Type of contract: (1)	individual policies	(2) group deferre	d annuity				
		(3) other (specify)	•	_					
	f	If contract purchased, in w	hole or in part to distri	bute benefits from a termin	nating plan i	check here	П		
7		tracts With Unallocated Fur	· · · · · · · · · · · · · · · · · · ·		<u> </u>				_
•		· ·	deposit administration			ion guarantee			
	а					ion guarantee			
		(3)	guaranteed investm	ent (4) dther	•				
							T		
	b	Balance at the end of the					7b		
	С	Additions: (1) Contribution		•					
		(2) Dividends and credits			7c(2)				
		(3) Interest credited during	•						
		(4) Transferred from separation			7c(4)				
		(5) Other (specify below)			7c(5)				
		•							
		(6)Total additions					7c(6)		C
	d	Total of balance and addition	ons (add lines 7b and 7	c(6))	···· <u></u>		7d		0
	е	Deductions:							
		(1) Disbursed from fund to	pay benefits or purchas	se annuities during year	7e(1)				
		(2) Administration charge r	nade by carrier		7e(2)				
		(3) Transferred to separate	account						
		(4) Other (specify below)			7e(4)				
		>							
		(5) Total deductions					7e(5)		

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

7f

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Schedule A (Form 5500) 2020

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such comployees, the entire group of such individual contracts with each	ntracts are experience-rated as a ur	nit. Where co	ontracts cover individual
8 Benefit and contract type (check all applicable boxes)	_		_
a ☐ Health (other than dental or vision) b☐ Dental	C Vision		d X Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disab	ility g Supplemental uner	nployment	h Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract		I Indemnity contract
m ☒ Other (specify) ► SUPP LIFE, ACCIDENTAL DEATH AND DISMEME	DEDMENT		
SUPPLIFE, ACCIDENTAL DEATH AND DISMEME	DERIVIENT		
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid			
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees			
(C) Other specific acquisition costs	0 (1)(T)		
(D) Other expenses	A (1) (=)		
(E) Taxes	A (4)(=)		
(F) Charges for risks or other contingencies	0-(4)(0)		
(G) Other retention charges	•	00(4)/[]	0
(H) Total retention	_	, , , , ,	U
(2) Dividends or retroactive rate refunds. (These amounts were paid			
d Status of policyholder reserves at end of year: (1) Amount held to provid			
(2) Claim reserves			
(3) Other reserves			
 e Dividends or retroactive rate refunds due. (Do not include amount entered 10 Nonexperience-rated contracts: 	ed in line 9c(2) .)	9e	
Total premiums or subscription charges paid to carrier		10a	1926450
		100	1323430
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 abo Specify nature of costs.		10b	
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to the company fail to provide an	nlete Schedule A2	Yes	⋈ No
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A?	Yes	X No
12 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2020

Employee Benefits Security Administration		File as an a	ttacnment to Form 55	00.				
Pension Benefit Guaranty Co	orporation							m is Open to Public Inspection
For calendar plan year 20	20 or fiscal plar	n year beginning 01/01/2020		and er	nding 12/3	31/2020		
A Name of plan HEALTH BENEFIT PLAN	N FOR EMPLO	YEES OF UNIVERSITY HEALTH	I, INC.		e-digit number (PN	۷) 🕨		501
				'		,		
C Plan sponsor's name a	as shown on line	e 2a of Form 5500		D Emplo	yer Identific	ation Num	nber (EIN)
UNIVERSITY HEALTH, I	NC.			58-	-1581102			
		rning Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca								
	(=) NIAIC	(d) Contract or	(e) Approximate nu	umber of		Policy	or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From		(g) To
36-2739571	79413	1204	284		01/01/202	0		12/31/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, a	and ot	ther persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com		ees. (Complete as many entries						
	(a) Name a	and address of the agent, broker,	or other person to whol	m commiss	ions or fees	were paid	1	
								Γ
(b) Amount of sales ar			s and other commission					
commissions pa	id	(c) Amount		(d) Purpos	e			(e) Organization code
	(a) Namo a	and address of the agent, broker,	or other person to when	m commiss	ions or foos	wore paid	,	
	(a) Name a	and address of the agent, broker,	or other person to who	III COITIIIISS	ions or rees	were paid		
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid				
commissions pa		(c) Amount	(d) Purpose			(e) Organization		(e) Organization code
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	500			9	cher	Jule A (Form 5500) 2020

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Schedule A (Form 5500) 2	2020	Page 2 – 1	
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	
	-		
	<u> </u>	Fees and other commissions paid	
(b) Amount of sales and base	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(o) / unount	(a) r diposo	code
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
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(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	<u>.</u>
(4)		, p p p	
	T		T.
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(5),	(2). 2.500	code
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Schedule A (Form 5500) 2020

Page 3

	art	Ш	Investment and Annuity Contract Information			
			Where individual contracts are provided, the entire group of such individual	dual contracts with each carrier may	be treated	d as a unit for purposes of
4	Cur	rent v	this report. alue of plan's interest under this contract in the general account at year e	and	4	
5			alue of plan's interest under this contract in separate accounts at year er		5	
6			With Allocated Funds:	id		
٠	a		e the basis of premium rates			
	_	Ola	o the basic of profitment ratios 7			
	b	Pre	miums paid to carrier		6b	
	C		miums due but unpaid at the end of the year		6c	
	d		e carrier, service, or other organization incurred any specific costs in con			
			ntion of the contract or policy, enter amount		6d	
		Spe	cify nature of costs			
	е	Тур	e of contract: (1) individual policies (2) group deferred	I annuity		
		(3)	other (specify)			
		` '	ш (1 7/			
	f	If co	ontract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here		
7			With Unallocated Funds (Do not include portions of these contracts mai			
•				te participation guarantee		
	а	тур	`'	te participation guarantee		
			(3) guaranteed investment (4) other			
	b	Bala	ance at the end of the previous year		7b	(
	С		itions: (1) Contributions deposited during the year	7c(1)		
		. ,	Dividends and credits	7c(2)		
		(3)	nterest credited during the year	7c(3)		
		` '	Transferred from separate account	7c(4)		
		(5)	Other (specify below)	7c(5)		
		P				
		(6)T	otal additions		7c(6)	(
	d	Tota	of balance and additions (add lines 7b and 7c(6)).		7d	(
	е	Dedu	uctions:			
		(1) [Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) A	dministration charge made by carrier	7e(2)		
		(3) T	ransferred to separate account	7e(3)		
		(4) (Other (specify below)	7e(4)		
		•				
		/ C \ T			7o(5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (Form 5500) 2020

8 Benefit and contract type (check, all applicable boxes) a	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such cont employees, the entire group of such individual contracts with each care.	racts are experience-rated as a ur	nit. Where contrac	ts cover individual
Temporary disability (accident and sickness) Temporary disability Supplemental unemployment Temporary Te	8 Benefit and contract type (check all applicable boxes)			
Stop loss (large deductible) j	a X Health (other than dental or vision) b ☐ Dental	c Vision	d	Life insurance
Stop loss (large deductible) j	e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabili	ty q Supplemental uner	nployment h	Prescription drug
9 Experience-rated contracts: a Premtums: (1) Amount received. (2) Increase (decrease) in unearned premium reserve. 9a(3) (3) Increase (decrease) in unearned premium reserve. 9a(3) (4) Earned ((1)+ (2) - (3)). 9 Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves. 9a(3) (3) Increase (decrease) in claim reserves. 9a(4) (4) Earned claims (add (4) and (2)). (2) Increase (decrease) in claim reserves. 9b(1) (2) Increase (decrease) in claim reserves. 9b(1) (2) Increase (decrease) in claim reserves. 9b(1) (3) Increase (decrease) in claim reserves. 9b(1) (4) Claims charged. 9b(1) (5) Increase (decrease) in claim reserves. 9b(1) (6) Chemistrative service or other fees. 9c(1)(A) 9b(1) (7) Chemistrative service or other fees. 9c(1)(B) (8) Administrative service or other fees. 9c(1)(B) (C) Other specific acquisition costs. 9c(1)(C) (D) Other expecific acquisition costs. 9c(1)(C) (E) Taxes. 9c(1)(C) (F) Charges for risks or other contingencies. 9c(1)(C) (G) Other retention charges. 9c(1)(C) (G) Other retention or security. 9c(1)(C) (D) Other retention or charges. re charges. 9c(1)(C) (D) Other retention or charges are charges. 9c(1)(C) (D) Other retention or charges. 9c(1)(C) (D) Other retention or charges. 9c(1)(C) (D) Other retention or charges. 9c(1)(C) (D) Other retention or charges. 9c(1)(C) (D) Other retention or charges. 9c(1)(C) (D) Other retention or charges. 9c(1)(C) (D) Other charges. 9c(1)(C) (D) Oth		* = * = * * * * * * * * * * * * * * * *	_ =	
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(3) Incurred claims (add (1) and (2)). (4) Claims charged. C Remainder of premium: (1) Retention charges (on an accrual basis) - (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (C) Other specific acquisition costs. (E) Taxes. (F) Charges for risks or other contingencies. (G) Other retention charges. (G) Other retention charges. (P) Charges for risks or other contingencies. (G) Other retention charges. (G) Other retendion charges. (P) Charges for risks or other contingencies. (P) Charges for risks or other contingencies. (G) Other retendion charges. (G) Other retendion charges. (P) Charges for risks or other contingencies. (P) Charges for risks or other contingencies. (G) Other retendion charges. (G) Other retendion charges. (D) Invidends or retroactive rate refunds. (E) Dividends or retroactive rate refunds due. (D) not include amount entered in line 9c(2). (B) Dividends or retroactive rate refunds due. (D) not include amount entered in line 9c(2). (D) Dividends or retroactive rate refunds due. (D) Nonexperience-rated contracts: (A) Other reserves. (B) 4(1) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C				
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(A) Commissions	()		522(1)	
(B) Administrative service or other fees (C) Other specific acquisition costs. (D) Other expenses (E) Taxes. (F) Charges for risks or other contingencies (F) Charges for risks or other contingencies (F) Charges for risks or other contingencies (G) Other retention charges (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.). (2) Claim reserves (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement 9d(2) (3) Other reserves (3) Other reserves (4) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).). 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier. a Total premiums or subscription charges paid to carrier. a Total premiums or subscription charges paid to carrier. a Total premiums or subscription charges paid to carrier. a Total premiums or subscription charges paid to carrier. 5 Pecify nature of costs. Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?		9c(1)(A)		
(C) Other specific acquisition costs. (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (F) Charges for risks or other contingencies. (G) Other retention charges. (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). (2) Claim reserves. (3) Other reserves. (3) Other reserves. (4) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line \$c(2)\$). (B) Dividends or retroactive rate refund		· · · · · ·		
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(G) Other retention charges		A (4)(=)		
(H) Total retention		0 (4)(0)		
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	. ,		9c(1)(H)	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	` '	_		<u>-</u> _
(2) Claim reserves				
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)				
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	· ·			
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier				
a Total premiums or subscription charges paid to carrier	,	d in line 9c(2).)	9e	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	·		100	4E1220
retention of the contract or policy, other than reported in Part I, line 2 above, report amount			104	451550
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?	retention of the contract or policy, other than reported in Part I, line 2 above		10b	
		lete Schedule A?	Yes X N	0
		ioto odliedule A:		· -

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2020

Employee Benefits Security Ad		File as a	n attachment to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the pursuant to ERISA section 103(a)(2).							
For calendar plan year 20	20 or fiscal pl	an year beginning 01/01/2020		and er	nding 12/3	31/2020	
A Name of plan				B Thre	e-digit		
HEALTH BENEFIT PLAN	FOR EMPL	OYEES OF UNIVERSITY HEAL	.TH, INC.	plan	number (PN	√)	501
					,	,	
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
UNIVERSITY HEALTH, I	NC.			58	-1581102		
		erning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
RELIASTAR LIFE INSURA	ANCE COMP.	ANY					
	(c) NAIC	(d) Contract or	(e) Approximate no	umber of		Policy or co	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To
41-0451140	67105	69051-1	5026		01/01/202	0	12/31/2020
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
		nmissions paid		(b) To	otal amount	of fees paid	
(-)		229132		(1)		'	24921
3 Persons receiving com		fees. (Complete as many entri	•				
	(a) Name	and address of the agent, broke	•	m commiss	ions or fees	were paid	
ACRISURE LLC			5 US-19 ALT M HARBOR, FL 34683				
(h) American of colors or	- d b	F	ees and other commissio	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	193518	0	WRITING AGENT				3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
HODGES - MACE BENEF	ITS GROUP		5-D GLENRIDGE DRIVE, ANTA, GA 30328	SUITE 350)		
(b) Amount of sales ar	nd base	F.	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	27618	24921	WRITING AGENT, SER	VICE FEE			3

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Schedule A (Form 5500) 2020 v. 200204

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Schedule A (Form 5500) 2020 Page **2** -(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid BENEFIT ADVISORS SERVICE GROUP LLC 1120 SANCTUARY PKWY SUITE 300 ALPHARETTA, GA 30097 Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 7996 0 **WRITING AGENT** 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (d) Purpose (c) Amount

commissions paid

code

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Schedule A (Form 5500) 2020

Page 3

F	Part I					
		Where individual contracts are provided, the entire group of such individual	dual contra	cts with each carrier ma	y be treated	as a unit for purposes of
1	Curro	this report.	and		4	
_		nt value of plan's interest under this contract in the general account at year on			5	
_		nt value of plan's interest under this contract in separate accounts at year er acts With Allocated Funds:	iu		J	
U		State the basis of premium rates				
	u	Otate the basis of premium rates				
	b	Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in con				
		retention of the contract or policy, enter amount			6d	
		Specify nature of costs •				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	l annuity			
		(3) other (specify)				
		(o) [] suiter (opensity)				
	f	If contract numbered in whole or in part to distribute honefite from a termin	otina nlon	abaak bara		
_		If contract purchased, in whole or in part, to distribute benefits from a termina				
′		acts With Unallocated Funds (Do not include portions of these contracts mai				
	а		te participat	tion guarantee		
		(3) guaranteed investment (4) dother				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		(6)Total additions			7c(6)	0
	d∃	otal of balance and additions (add lines 7b and 7c(6)).			7d	0
	e [Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
		•				
		The deductions			7o/5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

7f

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 92 of 115

Schedule A (Form 5500) 2020

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such con employees, the entire group of such individual contracts with each contracts.	tracts are experience-rated as a un	nit. Where contracts cover individual
8 Benefit and contract type (check all applicable boxes)		. 🗖
a ☐ Health (other than dental or vision) b ☐ Dental	c Vision	d Life insurance
e 🛚 Temporary disability (accident and sickness) 🔝 f 🔲 Long-term disabil	ity g 📗 Supplemental unen	nployment h Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract	I ☐ Indemnity contract
m ☐ Other (specify) ► ACCIDENT, CRITICAL ILLNESS	_	_
9 Experience-rated contracts:		
a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4) 0
b Benefit charges (1) Claims paid	a. (a)	
(2) Increase (decrease) in claim reserves		01 (0)
(3) Incurred claims (add (1) and (2))		9b(3) 0
(4) Claims charged		9b(4)
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies	9c(1)(F)	
(G) Other retention charges	9c(1)(G)	
(H) Total retention		9c(1)(H) 0
(2) Dividends or retroactive rate refunds. (These amounts were paid in	n cash, or 🔲 credited.)	9c(2)
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after retirement	9d(1)
(2) Claim reserves		9d(2)
(3) Other reserves		9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount entere	d in line 9c(2) .)	9e
10 Nonexperience-rated contracts:		
Total premiums or subscription charges paid to carrier		10a 1290117
b If the carrier, service, or other organization incurred any specific costs in or retention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.	connection with the acquisition or ve, report amount	10b
Part IV Provision of Information		
	uloto Schodulo A2	Yes X No
11 Did the insurance company fail to provide any information necessary to comp	nete Schedule A?	I ES VI INO
12 If the answer to line 11 is "Yes," specify the information not provided.		

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2021

This Form is Open to Public Inspection

					Inspection	
Part I	Annual Report Ide	entification Information				
For calend	lar plan year 2021 or fisca	al plan year beginning 01/01/2021	and ending 12/31/202	1		
A This ref	turn/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this participating employer information in accorda			ns.)
		🗙 a single-employer plan	a DFE (specify)			
B This return/report is:		the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12 r	nonths)	
C If the pl	lan is a collectively-barga	ined plan, check here	······			
D Check	box if filing under:	X Form 5558	automatic extension	th	e DFVC program	
		special extension (enter description	n)			
E If this is	a retroactively adopted p	olan permitted by SECURE Act section 2	201, check here			
Part II	Basic Plan Inform	nation—enter all requested information	n			
1a Name	•			1b	Three-digit plan number (PN) ▶	501
HEALTH	BENEFIT PLAN FOR EN	MPLOYEES OF UNIVERSITY HEALTH,	, INC.	1c	Effective date of pla	
					01/01/1969	
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 58-1581102	
UNIVERS	SITY HEALTH, INC.			2c	Plan Sponsor's tele number 706-722-9011	phone
	LTON WAY A, GA 30901			2d	Business code (see instructions) 622000	,

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	10/06/2022	DAVID BELKOSKI
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HEKE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2021) v. 210624

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	Form 5500 (2021)	Page 2		
3a	Plan administrator's name and address X Same as Plan Sponsor		3b Administra	itor's EIN
			3c Administra	tor's telephone
			number	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from		4b EIN	
а	Sponsor's name	· •	4d PN	
	Plan Name			
5	Total number of participants at the beginning of the plan year	d (vialfana mlana asimulata anki linaa Ca(4)	5	1894
6	Number of participants as of the end of the plan year unless otherwise states $6a(2)$, $6b$, $6c$, and $6d$).	d (weitare plans complete only lines 6a(1) ,		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	1809
a(2) Total number of active participants at the end of the plan year		6a(2)	2693
				101
b	Retired or separated participants receiving benefits		6b	104
С	Other retired or separated participants entitled to future benefits		6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d	2797
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	eceive benefits	6e	
f	Total. Add lines 6d and 6e		6f	
g	Number of participants with account balances as of the end of the plan year complete this item)	· ·	6g	
L			- Og	
	Number of participants who terminated employment during the plan year with less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans complete this item)	7	
8a	If the plan provides pension benefits, enter the applicable pension feature co			
b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E 4F 4H 4Q	des from the List of Plan Characteristics Code:	s in the instruction	ons.
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all the	at annly)	
Ja	(1) X Insurance	(1) X Insurance	ат арргу)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance contra	acts
	(3) Trust	(3) Trust		
	(4) X General assets of the sponsor	(4) X General assets of the s	ponsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the numl	ber attached. (S	ee instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation)	
	(O) D MD (Multi-analyses Defined Box 5t Discount Cont.)	(2) I (Financial Inform	nation – Small P	lan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3) X 5 A (Insurance Info	rmation)	
	actuary	(4) C (Service Provide	·	
		H	·	tion)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		-	•
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Schedule	es)

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 95 of 115

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2021

Department of Labo Employee Benefits Security Ad		File as an	attachment to Form 5	500.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This F				orm is Open to Public Inspection			
For calendar plan year 20.	21 or fiscal plar	n year beginning 01/01/2021		and en	ding 12/3	31/2021	1
A Name of plan HEALTH BENEFIT PLAN	FOR EMPLO	YEES OF UNIVERSITY HEALT	H, INC.		e-digit number (PI	N) •	501
C Plan sponsor's name a UNIVERSITY HEALTH, II		e 2a of Form 5500			yer Identific 1581102	cation Numbe	er (EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		1	(a) Approximate p	umber of		Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate n persons covered a		(5)		
	code	identification number	policy or contract	ct year	(1)	From	(g) To
39-1263473	73288	736882	2320		01/01/202	.1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and	d other persons in
	amount of com	missions paid		(b) To	otal amount	of fees paid	
		42717					8487
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
ACRISURE LLC DBA HEA	AD CAPITAL		HILLCREEK DRIVE JSTA, GA 30909				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	28478	0 0	COMMISSIONS				3
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
THOMAS W. MAYER			H ST E STE 500 Γ PAUL, MN 55101			·	
(In) Associated 5		Fe	es and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
	14239		COMMISSIONS				3
For Paperwork Reduction	on Act Notice,	see the Instructions for Form	5500.			Sch	nedule A (Form 5500) 2021

Schedule A (Form 5500) 2021 v. 201209

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 97 of 115

Schedule A (Form 5500) 2021 Page **2** -(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid ACRISURE LLC DBA ACHS INSURANCE 1201 TOWN PARK LANE **EVANS, GA 30809** Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 0 8487 3 **BONUS** (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (d) Purpose (c) Amount commissions paid code

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Schedule A (Form 5500) 2021

Page 3

	Part	II	Investment and Annuity Contract Information			
			Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier may	be treated	d as a unit for purposes of
4	Cur	rent v	this report. alue of plan's interest under this contract in the general account at year o	and	4	
5			alue of plan's interest under this contract in separate accounts at year er		5	
6			With Allocated Funds:			
٠	a		e the basis of premium rates			
	~	Ota	o the basic of profitant rates 7			
	b	Pre	niums paid to carrier		6b	
	C		niums due but unpaid at the end of the year		6c	
	d		e carrier, service, or other organization incurred any specific costs in cor			
			ntion of the contract or policy, enter amount		6d	
		Spe	cify nature of costs			
	е	Тур	e of contract: (1) 🔲 individual policies (2) 📗 group deferred	l annuity		
		(3)	other (specify)			
		` ,				
	f	If co	ontract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7			With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>		
•			_ ` _ `	te participation guarantee		
	а	тур	· · · · · · · · · · · · · · · · · · ·	te participation guarantee		
			(3) ☐ guaranteed investment (4) ☐ other ▶			
	b		ance at the end of the previous year		7b	(
	С		itions: (1) Contributions deposited during the year	7c(1)		
		٠,	Dividends and credits	7c(2)		
		٠,	nterest credited during the year	7c(3)		
		` '	Fransferred from separate account	7c(4)		
		(5)	Other (specify below)	7c(5)		
		•				
		(6)T	otal additions		7c(6)	(
	d	Tota	of balance and additions (add lines 7b and 7c(6)).		7d	(
	е	Dedu	actions:			
		(1) [isbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) A	dministration charge made by carrier	7e(2)		
		. ,	ransferred to separate account	7e(3)		
		(4) (Other (specify below)	7e(4)		
		•				
		(E) T			7o(5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 99 of 115

Schedule A (Form 5500) 2021

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the the information may be combined for reporting purposes if such contemployees, the entire group of such individual contracts with each care.	tracts are exp	perience-rated as a un	t. Where cor	ntracts cover individual
8 Benefit and contract type (check all applicable boxes)	г	_		. 🖂
a Health (other than dental or vision)	С	X Vision		d Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabili	ity g	Supplemental unem	ployment	h Prescription drug
i Stop loss (large deductible) j HMO contract	k	PPO contract		I Indemnity contract
m ☐ Other (specify) ▶	·	_		
9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve				
(4) Earned ((1) + (2) - (3))		1	9a(4)	0
b Benefit charges (1) Claims paid			1 ()	
(2) Increase (decrease) in claim reserves				
(3) Incurred claims (add (1) and (2))			9b(3)	0
(4) Claims charged			9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid ir	n cash, or	credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide		·	9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
Dividends or retroactive rate refunds due. (Do not include amount entered			9e	
Nonexperience-rated contracts:	<u> </u>	, ,	1	
Total premiums or subscription charges paid to carrier			10a	317232
b If the carrier, service, or other organization incurred any specific costs in c				
retention of the contract or policy, other than reported in Part I, line 2 above	/e, report am	ount	10b	
Specify nature of costs.				
Part IV Provision of Information				
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to comp	1-4-0 ! ::	- A0	Yes	X No

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2021

Department of Labo Employee Benefits Security Ad		▶ File as an	attachment to Form 55	00.	,			
Pension Benefit Guaranty Co	orporation	•	are required to provide t ERISA section 103(a)(2)		ion	This Fo	This Form is Open to Public Inspection	
For calendar plan year 20	21 or fiscal pla	n year beginning 01/01/2021		and en	ding 12/3	31/2021		
A Name of plan HEALTH BENEFIT PLAN	N FOR EMPLO	YEES OF UNIVERSITY HEALT	TH, INC.		e-digit number (PI	N) •	501	
C Plan sponsor's name a UNIVERSITY HEALTH, I		e 2a of Form 5500		· ·	yer Identific 1581102	cation Number	(EIN)	
		rning Insurance Contract. Individual contracts grouped						
1 Coverage Information:		3 ,				J		
(a) Name of insurance ca LIFE INSURANCE COMP		TH AMERICA						
(I-) FINI	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
23-1503749	65498	FLX 98014,3-4*	7570		01/01/202	1	12/31/2021	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in	
<u> </u>	amount of com	missions paid		(b) To	otal amount	of fees paid		
χ-,		155686		<u> </u>			27730	
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).				
•		and address of the agent, broke			ions or fees	were paid		
LOCKTON COMPANIES,	LLC	РО В	Г 3042 ОХ 123042 AS, TX 75312					
(b) Amount of sales a	nd hooo	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code	
155686		27730	SALES AND SERVICE (VERRIDE			3	
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales a	nd base	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
For Paperwork Reduction	on Act Notice,	see the Instructions for Form	5500.			Sche	edule A (Form 5500) 2021	

v. 201209

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Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent broke	er, or other person to whom commissions or fees were paid	•
(a) 1101	The aria address of the agent, protect	n, di carioi porconi te wiloni commiscione di 1666 word para	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent. broke	er, or other person to whom commissions or fees were paid	
1-7	<i>y</i> ,	, <u> </u>	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1			
	l		

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Schedule A (Form 5500) 2021

Page 3

Part		II	Investment and Annuity Contract Information			
			Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier may	be treated	d as a unit for purposes of
4	Cur	rent v	this report. alue of plan's interest under this contract in the general account at year o	and	4	
5			alue of plan's interest under this contract in separate accounts at year er		5	
6			With Allocated Funds:			
٠	a		e the basis of premium rates			
	~	Ota	o the basic of profitant rates 7			
	b	Pre	niums paid to carrier		6b	
	C		niums due but unpaid at the end of the year		6c	
	d		e carrier, service, or other organization incurred any specific costs in cor			
			ntion of the contract or policy, enter amount		6d	
		Spe	cify nature of costs			
	е	Тур	e of contract: (1) 🔲 individual policies (2) 📗 group deferred	l annuity		
		(3)	other (specify)			
		` ,				
	f	If co	ontract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7			With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>		
•			_ ` _ `	te participation guarantee		
	а	тур	· · · · · · · · · · · · · · · · · · ·	te participation guarantee		
			(3) ☐ guaranteed investment (4) ☐ other ▶			
	b		ance at the end of the previous year		7b	(
	С		itions: (1) Contributions deposited during the year	7c(1)		
		٠,	Dividends and credits	7c(2)		
		٠,	nterest credited during the year	7c(3)		
		` '	Fransferred from separate account	7c(4)		
		(5)	Other (specify below)	7c(5)		
		•				
		(6)T	otal additions		7c(6)	(
	d	Tota	of balance and additions (add lines 7b and 7c(6)).		7d	(
	е	Dedu	actions:			
		(1) [isbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) A	dministration charge made by carrier	7e(2)		
		. ,	ransferred to separate account	7e(3)		
		(4) (Other (specify below)	7e(4)		
		•				
		(E) T			7o(5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (Form	5500	2021

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employee the information may be combined for reporting purposes if suc employees, the entire group of such individual contracts with expressions.	h contracts are experience-rated as a ur	nit. Where contracts cover individual
8 Benefit and contract type (check all applicable boxes)	<u></u>	_
a ☐ Health (other than dental or vision) b ☐ Dental	C Vision	d X Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term of	disability g Supplemental unen	nployment h Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contra	- -	I Indemnity contract
m X Other (specify) ▶ SUPP LIFE, ACCIDENTAL DEATH AND DISM	-	
Outer (speedily) 7 SUPP LIFE, ACCIDENTAL DEATH AND DISK	MEMBERMENT	
9 Experience-rated contracts:		
a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))		9a(4)
b Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		9b(3)
(4) Claims charged		9b(4)
c Remainder of premium: (1) Retention charges (on an accrual basis		
(A) Commissions	· · · · · · · · · · · · · · · · · · ·	
(B) Administrative service or other fees		
(C) Other specific acquisition costs	a (4)(=)	
(D) Other expenses	0-(4)(5)	
(E) Taxes	A (4) (=)	
(F) Charges for risks or other contingencies	0-(4)(0)	
(G) Other retention charges		9c(1)(H)
(H) Total retention.		
(2) Dividends or retroactive rate refunds. (These amounts were		
d Status of policyholder reserves at end of year: (1) Amount held to p		
(2) Claim reserves		
(3) Other reserves e Dividends or retroactive rate refunds due. (Do not include amount of		· · · · · · · · · · · · · · · · · · ·
10 Nonexperience-rated contracts:	eritered in line 90(2) .)	36
Total premiums or subscription charges paid to carrier		10a 209131
		200101
b If the carrier, service, or other organization incurred any specific corretention of the contract or policy, other than reported in Part I, line Specify nature of costs.		10b
Part IV Provision of Information	complete Schedule A?	Yes ⊠ No
	complete Schedule A?	Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	•	

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2021

Employee Benefits Security Administration File as an attachment to Form 5500.								
Pension Benefit Guaranty Co	orporation		panies are required to provide the information uant to ERISA section 103(a)(2).			This For	This Form is Open to Public Inspection	
For calendar plan year 20	21 or fiscal plar	year beginning 01/01/2021		and en	ding 12/3	31/2021		
A Name of plan HEALTH BENEFIT PLAN	N FOR EMPLOY	/EES OF UNIVERSITY HEALTH,	INC.	B Three plan	e-digit number (PI	N) •	501	
C Plan sponsor's name a	as shown on line	e 2a of Form 5500		D Emplo	yer Identific	cation Number ((EIN)	
UNIVERSITY HEALTH, I	NC.			58-	1581102			
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca UNITED HEALTHCARE (A								
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To	
36-2739571	79413	1204	43		01/01/202	1	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total	amount of comr	nissions paid		(b) To	tal amount	of fees paid		
3 Persons receiving com		ees. (Complete as many entries a						
		nd address of the agent, broker, o	or other person to who		ions or lees	s were paid		
(b) Amount of sales a commissions pa		(c) Amount		(d) Purpose	<u> </u>		(e) Organization code	
		(0)		(4) - 4: poo			(v) organization out	
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales a	nd base	<u>F</u> ees	and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code	
For Paperwork Reduction	on Act Notice, s	see the Instructions for Form 55	500.			Sched	dule A (Form 5500) 2021	

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Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Nai	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
	-		
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	(d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) i dipose	code
(a) Nai	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent hi	roker, or other person to whom commissions or fees were paid	
(a) Nai	The and address of the agent, bi	oker, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base	(a) Amt	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Schedule A (Form 5500) 2021

Page 3

Part II		II	Investment and Annuity Contract Information						
			Where individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided, the entire group of such individual contracts are provided.	dual contracts with each carrier may	be treated	I as a unit for purposes of			
4	Curr	rent v	this report. alue of plan's interest under this contract in the general account at year e	end	4				
5			alue of plan's interest under this contract in separate accounts at year er		5				
6			With Allocated Funds:						
	а	Stat	e the basis of premium rates						
			•						
	b	Prer	miums paid to carrier		6b				
	С	Prer	niums due but unpaid at the end of the year		6c				
	d		e carrier, service, or other organization incurred any specific costs in conntion of the contract or policy, enter amount		6d				
		Spe	cify nature of costs						
	е		e of contract: (1) individual policies (2) group deferred other (specify)	l annuity					
	f	If co	ontract purchased, in whole or in part, to distribute benefits from a termina	ating plan, check here					
7			With Unallocated Funds (Do not include portions of these contracts mai						
•	a			te participation guarantee					
	<u> </u>	, yp.	(3) guaranteed investment (4) other	F					
			(5) Guaranteed investment (4) Guiler 7						
	b	Rala	ance at the end of the previous year		7b	0			
	C		itions: (1) Contributions deposited during the year	7c(1)	7.0				
	•		Dividends and credits	7c(2)					
		. ,	nterest credited during the year	7c(3)					
		. ,	Fransferred from separate account	7c(4)					
		` '	Other (specify below)	7c(5)					
		È							
		(6)T	otal additions		7c(6)	0			
	d	` '	of balance and additions (add lines 7b and 7c(6)).		7d	0			
			actions:						
			Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		. ,	dministration charge made by carrier	7e(2)					
		. ,	ransferred to separate account	7e(3)					
		. ,	Other (specify below)	7e(4)					
)	\ <i>\-\-</i>	- \ - \ - \					
		,							
					70(F)				
					/O/h				

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

7f

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Schedule A (Form 5500) 2021

Part III	Welfare Benefit Contract Inform	ation				
	If more than one contract covers the same					
	the information may be combined for repor					
	employees, the entire group of such individ		arrier may be	treated as a unit for pu	urposes of t	nis report.
8 Benefit a	and contract type (check all applicable boxes)					
а 🛚 н	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance
e 🗌 T	emporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	ployment	h Prescription drug
i 🗌 s	top loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract
m∏o	ther (specify)					
ш						
9 Experien	ce-rated contracts:					
	niums: (1) Amount received		9a(1)			
	Increase (decrease) in amount due but unpai		9a(2)			
	Increase (decrease) in unearned premium re		9a(3)			
	Earned ((1) + (2) - (3))				9a(4)	0
	nefit charges (1) Claims paid				1 ()	
	Increase (decrease) in claim reserves					
	Incurred claims (add (1) and (2))				9b(3)	0
	Claims charged				9b(4)	
` '	mainder of premium: (1) Retention charges (• • • • • • • • • • • • • • • • • • • •	
	(A) Commissions	•	9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges					
	(H) Total retention				9c(1)(H)	0
	Dividends or retroactive rate refunds. (These				9c(2)	
	tus of policyholder reserves at end of year: (9d(1)	
	Claim reserves				9d(1)	
` '					9d(3)	
` ,	Other reservesidends or retroactive rate refunds due. (Do n				9a(3)	
	perience-rated contracts:	ot illolude allioulit elitere	u III IIIIe 30(2)	1.]	36	
	al premiums or subscription charges paid to	parrier			10a	65245
_					100	03243
rete	ne carrier, service, or other organization incurention of the contract or policy, other than rep nature of costs.				10b	
Part IV	Provision of Information					
	insurance company fail to provide any inform	nation necessary to semi	lata Schodula	Δ2 Π	Yes	X No
			iele ocheuule	ΣΛ:		
ı∡ ırtne a	nswer to line 11 is "Yes," specify the informat	ion not provided. 🕨				

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2021

Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This F	orm is Open to Public Inspection			
For calendar plan year 20	21 or fiscal plai	n year beginning 01/01/2021		and er	nding 12/3	31/2021	
A Name of plan HEALTH BENEFIT PLAN	I FOR EMPLO	YEES OF UNIVERSITY HEALT	TH, INC.		e-digit number (PI	N) •	501
C Plan sponsor's name a UNIVERSITY HEALTH, II		e 2a of Form 5500		-	oyer Identific -1581102	ation Numbe	r (EIN)
		rning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		NY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				contract year
(2) =:: (code	identification number	policy or contrac		(f)	From	(g) To
41-0451140	67105	69051-1	4564		01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
		217692					27242
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees	were paid	
ACRISURE LLC			US-19 ALT 1 HARBOR, FL 34683				
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	183516	0 \	WRITING AGENT				3
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees	were paid	•
HODGES - MACE BENEF	ITS GROUP IN		-D GLENRIDGE DRIVE, NTA, GA 30328	SUITE 350)		
(b) Amount of sales ar			ees and other commissio				
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code
	26796	27242	WRITING AGENT, SER\	/ICE FEE			3
Fan Bananania Bankarik	n Act Notice	and the Instructions for Form	5500			Cala	adula A (Form FEOO) 2021

v. 201209

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 109 of 115

Schedule A (Form 5500) 2021 Page **2** -(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid BENEFIT ADVISORS SERVICE GROUP LLC 1120 SANCTUARY PKWY SUITE 300 ALPHARETTA, GA 30009 Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code 7380 0 WRITING AGENT 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (c) Amount (d) Purpose commissions paid code (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (e) (b) Amount of sales and base Organization (d) Purpose (c) Amount commissions paid code

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Schedule A (Form 5500) 2021

Page 3

ı	Part	II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier may	be treated	d as a unit for purposes of
_			this report.		_	
			alue of plan's interest under this contract in the general account at year		4	
			alue of plan's interest under this contract in separate accounts at year er	nd	5	
6			With Allocated Funds:			
	а	Stat	e the basis of premium rates			
		_			O.L.	
	b		miums paid to carrier		6b	
	C _.		miums due but unpaid at the end of the year		6c	
	d		e carrier, service, or other organization incurred any specific costs in cor ntion of the contract or policy, enter amount		6d	
		Spe	cify nature of costs			
		•	•			
	е	Type	e of contract: (1) individual policies (2) group deferred	d annuity		
		(3)		,		
		(3)	Unter (specify)			
	f	If oc	ontract purchased, in whole or in part, to distribute benefits from a termin	ating plan shock bars		
7			· · · · · · · · · · · · · · · · · · ·			
1			With Unallocated Funds (Do not include portions of these contracts ma	·		
	а	Тур		te participation guarantee		
			(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Bala	ance at the end of the previous year		7b	(
	С	Add	itions: (1) Contributions deposited during the year	7c(1)		
		(2) [Dividends and credits	7c(2)		
		(3) I	nterest credited during the year	7c(3)		
		(4)	Fransferred from separate account	7c(4)		
		(5) (Other (specify below)	7c(5)		
		•				
		(6)T	otal additions		7c(6)	C
	d	` '	of balance and additions (add lines 7b and 7c(6)).		7d	
	е		uctions:			
			Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		. ,	dministration charge made by carrier	7e(2)		
		. ,	ransferred to separate account	7e(3)		
		. ,	Other (specify below)	7e(4)		
		(.) C	(2,55)	(-/		
		•				
		(5) T	otal deductions		7e(5)	C

f Balance at the end of the current year (subtract line 7e(5) from line 7d).....

7f

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Schedule A (Form 5500) 2021

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contract the information may be combined for reporting purposes if such contract the information may be combined for reporting purposes if such contract the information may be combined for reporting purposes.			
employees, the entire group of such individual contracts with each of			
8 Benefit and contract type (check all applicable boxes)	_	_	
a ☐ Health (other than dental or vision) b ☐ Dental	C Vision	d 🗌	Life insurance
e X Temporary disability (accident and sickness) f Long-term disabil	lity g Supplemental un	employment h	Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract	ıñ	Indemnity contract
m ☒ Other (specify) ► ACCIDENT, CRITICAL ILLNESS	ш		•
Marie (Costa)) Addibent, Chimoae Illeness			
9 Experience-rated contracts:			
a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E) 9c(1)(F)		
(F) Other retestion charges			
(G) Other retention charges(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid i	_		
d Status of policyholder reserves at end of year: (1) Amount held to provide (2) Claim reserves		· · · · ·	
(3) Other reserves		:-:	
Dividends or retroactive rate refunds due. (Do not include amount entere			
10 Nonexperience-rated contracts:	00(2).		
a Total premiums or subscription charges paid to carrier		10a	1223435
b If the carrier, service, or other organization incurred any specific costs in			
retention of the contract or policy, other than reported in Part I, line 2 abo Specify nature of costs.	ve, report amount	10b	
Part IV Provision of Information			
	slata Cabadula AO	Yes X No	
11 Did the insurance company fail to provide any information necessary to comp	DIETE Schedule A?	res No	J
12 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

2021

Department of Labor Employee Benefits Security Administration		▶ File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	prporation	▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection		
For calendar plan year 20.	21 or fiscal plar	year beginning 01/01/2021		and en	ding 12/3	1/2021	-
A Name of plan HEALTH BENEFIT PLAN	H, INC.	B Three-digit plan number (PN) ▶			501		
C Plan sponsor's name a UNIVERSITY HEALTH, II		e 2a of Form 5500		-	yer Identific 1581102	ation Number	(EIN)
	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca		I	(e) Approximate n	umbor of		Policy or o	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	at end of	(f)	From	(g) To
06-6033492	60054	AE467651		policy or contract year 260		1	12/31/2021
2 Insurance fee and com descending order of the		I ition. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
	amount of comr	nissions paid		(b) To	tal amount	of fees paid	
		30000					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
ACRISURE LLC DBA HEA	AD CAPITAL		SORS 2840 HILL CREE ISTA, GA 30909	K DRIVE			
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
30000		0 0	COMMISSIONS				3
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
		-					
(b) Amount of sales and base		Fees and other commiss					
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
For Paperwork Reduction	n Act Notice, s	see the Instructions for Form	5500.			Sche	edule A (Form 5500) 2021

Schedule A (Form 5500) 2021 v. 201209

Case 1:23-cv-00047-JRH-BKE Document 25-1 Filed 06/14/23 Page 113 of 115

Schedule A (Form 5500) 2	2021	Page 2 – 1				
(a) Nai	me and address of the agent, br	oker, or other person to whom commissions or fees were paid				
	-					
	<u> </u>					
(b) Amount of sales and base	() ()	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nai	me and address of the agent, br	oker, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(0)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	(e) Organization			
commissions paid	(c) Amount	(u) i dipose	code			
(a) Nai	me and address of the agent, br	oker, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Na	me and address of the agent hr	oker, or other person to whom commissions or fees were paid	<u> </u>			
(a) Nai	ne and address of the agent, bi	oker, or other person to whom commissions or rees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nai	me and address of the agent, br	oker, or other person to whom commissions or fees were paid				
	<u> </u>					
(b) Amount of sales and base	(a) Amount	Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Schedule A (Form 5500) 2021

Page 3

	Part	II	Investment and Annuity Contract Information			
			Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier may	be treated	d as a unit for purposes of
4	Cur	rent v	this report. alue of plan's interest under this contract in the general account at year o	and	4	
5			alue of plan's interest under this contract in separate accounts at year er		5	
6			With Allocated Funds:			
٠	a		e the basis of premium rates			
	a State the basis of premium rates •					
	b	Pre	niums paid to carrier		6b	
	C		niums due but unpaid at the end of the year		6c	
	d					
			ntion of the contract or policy, enter amount		6d	
		Spe	cify nature of costs			
	е	Тур	e of contract: (1) 🔲 individual policies (2) 📗 group deferred	l annuity		
		(3)	other (specify)			
		` ,				
	f	If co	ontract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7			With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>		
•			_ ` _ `	te participation guarantee		
	а	тур	· · · · · · · · · · · · · · · · · · ·	te participation guarantee		
			(3) ☐ guaranteed investment (4) ☐ other ▶			
	b		ance at the end of the previous year		7b	(
	С		itions: (1) Contributions deposited during the year	7c(1)		
		٠,	Dividends and credits	7c(2)		
		٠,	nterest credited during the year	7c(3)		
		` '	Fransferred from separate account	7c(4)		
		(5)	Other (specify below)	7c(5)		
		•				
		(6)T	otal additions		7c(6)	(
	d	Tota	of balance and additions (add lines 7b and 7c(6)).		7d	(
	е	Dedu	actions:			
		(1) [isbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) A	dministration charge made by carrier	7e(2)		
		. ,	ransferred to separate account	7e(3)		
		(4) (Other (specify below)	7e(4)		
		•				
		(E) T			7o(5)	

Balance at the end of the current year (subtract line 7e(5) from line 7d).....

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Schedule A (Form 5500) 2021

Part III	Welfare Benefit Contract Inform	ation				
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s),						
	the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.					
			arrier may be	treated as a unit for p	urposes of t	his report.
8 Benefit a	and contract type (check all applicable boxes)					
а 🗌 н	ealth (other than dental or vision)	b Dental	c	Vision		d Life insurance
е 🗌 Т	emporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	ployment	h Prescription drug
i 🗌 s	top loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
m∏o	Other (specify)	_	_			_
ш -	(1)/					
9 Experien	nce-rated contracts:					
•	niums: (1) Amount received		9a(1)			
	Increase (decrease) in amount due but unpai		9a(2)			
	Increase (decrease) in unearned premium res		9a(3)			_
	Earned ((1) + (2) - (3))				9a(4)	0
	nefit charges (1) Claims paid				1 ()	
	Increase (decrease) in claim reserves					
` ,	Incurred claims (add (1) and (2))				9b(3)	0
	Claims charged				9b(4)	
` '	mainder of premium: (1) Retention charges (
	(A) Commissions	·	9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.		9c(1)(F)			
	(G) Other retention charges					
	(H) Total retention				9c(1)(H)	0
	Dividends or retroactive rate refunds. (These				9c(2)	
	itus of policyholder reserves at end of year: (1		<u></u>		9d(1)	
	Claim reserves	•			9d(2)	
` '	Other reserves				9d(3)	
` ,	idends or retroactive rate refunds due. (Do n				9e	
	perience-rated contracts:		<u></u>	<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	al premiums or subscription charges paid to	carrier			10a	228542
_					100	
rete	b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount					
Part IV Provision of Information						
		nation necessary to comm	lata Schodule	- Д2	Yes	X No
The bit the insurance company tall to provide any information necessary to complete concedure?:						
12 If the answer to line 11 is "Yes," specify the information not provided.						